

<p style="text-align: right;">Page 1</p> <p>IN THE UNITED STATES DISTRICT COURT FOR THE EASTERN DISTRICT OF OHIO EASTERN DIVISION</p> <p>- - -</p> <p>IN RE: NATIONAL : MDL NO. 2804 PRESCRIPTION OPIATE : LITIGATION :</p> <p>-----</p> <p>: CASE NO. THIS DOCUMENT : 1:17-MD-2804 RELATES TO ALL CASES: : Hon. Dan A. : Polster - - - Tuesday, January 8, 2019 - - - HIGHLY CONFIDENTIAL - SUBJECT TO FURTHER CONFIDENTIALITY REVIEW</p> <p>- - -</p> <p>Videotaped deposition of DEBORAH BEARER, taken pursuant to notice, was held at the offices of Golkow Litigation Services, One Liberty Place, 1650 Market Street, Suite 5150, Philadelphia, Pennsylvania 19103, beginning at 9:30 a.m., on the above date, before Amanda Dec Maslynsky-Miller, a Certified Realtime Reporter.</p> <p>- - -</p> <p>GOLKOW LITIGATION SERVICES 877.370.3377 ph 917.591.5672 fax deps@golkow.com</p>	<p style="text-align: right;">Page 2</p> <p>1 APPEARANCES:</p> <p>2</p> <p>3 WAGSTAFF & CARTMELL, LLP</p> <p>4 BY: SARAH S. 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Parks Avenue</p> <p>19 Suite 200</p> <p>20 Nashville, Tennessee 37203</p> <p>21 (877) 369-0267</p> <p>22 Beng@bsjfirm.com</p> <p>23 Representing the Staubus Plaintiffs</p> <p>24</p> <p>25</p> <p>26</p> <p>27</p> <p>28</p> <p>29</p> <p>30</p> <p>31</p> <p>32</p> <p>33</p> <p>34</p> <p>35</p> <p>36</p> <p>37</p> <p>38</p> <p>39</p> <p>40</p> <p>41</p> <p>42</p> <p>43</p> <p>44</p> <p>45</p> <p>46</p> <p>47</p> <p>48</p> <p>49</p> <p>50</p> <p>51</p> <p>52</p> <p>53</p> <p>54</p> <p>55</p> <p>56</p> <p>57</p> <p>58</p> <p>59</p> <p>60</p> <p>61</p> <p>62</p> <p>63</p> <p>64</p> <p>65</p> <p>66</p> <p>67</p> <p>68</p> <p>69</p> <p>70</p> <p>71</p> <p>72</p> <p>73</p> <p>74</p> <p>75</p> <p>76</p> <p>77</p> <p>78</p> <p>79</p> <p>80</p> <p>81</p> <p>82</p> <p>83</p> <p>84</p> <p>85</p> <p>86</p> <p>87</p> <p>88</p> <p>89</p> <p>90</p> <p>91</p> <p>92</p> <p>93</p> <p>94</p> <p>95</p> <p>96</p> <p>97</p> <p>98</p> <p>99</p> <p>100</p> <p>101</p> <p>102</p> <p>103</p> <p>104</p> <p>105</p> 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<p style="text-align: right;">Page 3</p> <p>1 APPEARANCES: (Continued)</p> <p>2</p> <p>3 PIETRAGALLO GORDON ALFANO BOSICK &</p> <p>4 RASPANTI, LLP</p> <p>5 BY: LESLIE A. MARIOTTI, ESQUIRE</p> <p>6 1818 Market Street</p> <p>7 Suite 3402</p> <p>8 Philadelphia, Pennsylvania 19103</p> <p>9 (215) 320-6200</p> <p>10 LAM@pietragallos.com</p> <p>11 Representing the Defendant,</p> <p>12 Cardinal Health, Inc.</p> <p>13</p> <p>14</p> <p>15</p> <p>16</p> <p>17 JONES DAY</p> <p>18 BY: SHUBHA M. HARRIS, ESQUIRE</p> <p>19 90 South Seventh Street</p> <p>20 Suite 4950</p> <p>21 Minneapolis, MN 55402</p> <p>22 (612) 217-8800</p> <p>23 Shubhaharris@jonesday.com</p> <p>24 Representing the Defendant,</p> <p>25 Walmart</p> <p>26</p> <p>27</p> <p>28</p> <p>29</p> <p>30</p> <p>31</p> <p>32</p> <p>33</p> <p>34</p> <p>35</p> <p>36</p> <p>37</p> <p>38</p> <p>39</p> <p>40</p> <p>41</p> <p>42</p> <p>43</p> <p>44</p> <p>45</p> <p>46</p> <p>47</p> <p>48</p> <p>49</p> <p>50</p> <p>51</p> <p>52</p> <p>53</p> <p>54</p> <p>55</p> <p>56</p> <p>57</p> <p>58</p> <p>59</p> <p>60</p> <p>61</p> <p>62</p> <p>63</p> <p>64</p> <p>65</p> <p>66</p> <p>67</p> <p>68</p> <p>69</p> <p>70</p> <p>71</p> <p>72</p> <p>73</p> <p>74</p> <p>75</p> <p>76</p> <p>77</p> <p>78</p> <p>79</p> <p>80</p> <p>81</p> <p>82</p> <p>83</p> <p>84</p> <p>85</p> <p>86</p> <p>87</p> <p>88</p> <p>89</p> <p>90</p> <p>91</p> <p>92</p> <p>93</p> <p>94</p> <p>95</p> <p>96</p> <p>97</p> <p>98</p> <p>99</p> <p>100</p> <p>101</p> <p>102</p> <p>103</p> <p>104</p> <p>105</p> <p>106</p> <p>107</p> <p>108</p> <p>109</p> <p>110</p> <p>111</p> <p>112</p> <p>113</p> <p>114</p> <p>115</p> <p>116</p> <p>117</p> <p>118</p> <p>119</p> <p>120</p> <p>121</p> <p>122</p> <p>123</p> <p>124</p> <p>125</p> <p>126</p> <p>127</p> <p>128</p> <p>129</p> <p>130</p> <p>131</p> <p>132</p> <p>133</p> <p>134</p> <p>135</p> <p>136</p> <p>137</p> <p>138</p> <p>139</p> <p>140</p> <p>141</p> <p>142</p> <p>143</p> <p>144</p> <p>145</p> <p>146</p> <p>147</p> <p>148</p> <p>149</p> <p>150</p> <p>151</p> <p>152</p> <p>153</p> <p>154</p> <p>155</p> <p>156</p> <p>157</p> <p>158</p> <p>159</p> <p>160</p> <p>161</p> <p>162</p> <p>163</p> <p>164</p> <p>165</p> <p>166</p> <p>167</p> <p>168</p> <p>169</p> <p>170</p> <p>171</p> <p>172</p> <p>173</p> <p>174</p> <p>175</p> <p>176</p> <p>177</p> <p>178</p> <p>179</p> <p>180</p> <p>181</p> <p>182</p> <p>183</p> <p>184</p> <p>185</p> <p>186</p> <p>187</p> <p>188</p> <p>189</p> <p>190</p> <p>191</p> <p>192</p> <p>193</p> <p>194</p> <p>195</p> <p>196</p> <p>197</p> <p>198</p> <p>199</p> <p>200</p> <p>201</p> <p>202</p> <p>203</p> <p>204</p> <p>205</p> <p>206</p> <p>207</p> <p>208</p> <p>209</p> <p>210</p> <p>211</p> <p>212</p> <p>213</p> <p>214</p> <p>215</p> <p>216</p> <p>217</p> <p>218</p> <p>219</p> <p>220</p> <p>221</p> <p>222</p> <p>223</p> <p>224</p> <p>225</p> <p>226</p> <p>227</p> <p>228</p> <p>229</p> <p>230</p> <p>231</p> <p>232</p> <p>233</p> <p>234</p> <p>235</p> <p>236</p> <p>237</p> <p>238</p> <p>239</p> <p>240</p> <p>241</p> <p>242</p> <p>243</p> <p>244</p> <p>245</p> <p>246</p> <p>247</p> <p>248</p> <p>249</p> <p>250</p> <p>251</p> <p>252</p> <p>253</p> <p>254</p> <p>255</p> <p>256</p> <p>257</p> <p>258</p> <p>259</p> <p>260</p> <p>261</p> <p>262</p> <p>263</p> <p>264</p> <p>265</p> <p>266</p> <p>267</p> <p>268</p> <p>269</p> <p>270</p> <p>271</p> <p>272</p> <p>273</p> <p>274</p> <p>275</p> <p>276</p> <p>277</p> <p>278</p> <p>279</p> <p>280</p> <p>281</p> <p>282</p> <p>283</p> <p>284</p> <p>285</p> <p>286</p> <p>287</p> <p>288</p> <p>289</p> <p>290</p> <p>291</p> <p>292</p> <p>293</p> <p>294</p> <p>295</p> <p>296</p> <p>297</p> <p>298</p>	

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<p style="text-align: right;">Page 9</p> <p>1 - - -</p> <p>2 (It is hereby stipulated and</p> <p>3 agreed by and among counsel that</p> <p>4 sealing, filing and certification</p> <p>5 are waived; and that all</p> <p>6 objections, except as to the form</p> <p>7 of the question, will be reserved</p> <p>8 until the time of trial.)</p> <p>9 - - -</p> <p>10 VIDEO TECHNICIAN: We're now</p> <p>11 on the record. My name is David</p> <p>12 Lane, videographer for Golkow</p> <p>13 Litigation Services. Today's date</p> <p>14 is January 8th, 2019. The time is</p> <p>15 9:30 a m.</p> <p>16 This deposition is taking</p> <p>17 place in Philadelphia,</p> <p>18 Pennsylvania, in the matter of</p> <p>19 National Prescription Opioid</p> <p>20 Litigation. Our deponent today is</p> <p>21 Deborah Bearer. Counsel will be</p> <p>22 noted on the stenographic record.</p> <p>23 The court reporter is Amanda</p> <p>24 Miller and will now swear in our</p>	<p style="text-align: right;">Page 10</p> <p>1 witness.</p> <p>2 - - -</p> <p>3 DEBORAH BEARER, after having</p> <p>4 been duly sworn, was examined and</p> <p>5 testified as follows:</p> <p>6 - - -</p> <p>7 VIDEO TECHNICIAN: Please</p> <p>8 begin.</p> <p>9 - - -</p> <p>10 EXAMINATION</p> <p>11 - - -</p> <p>12 BY MS. RUANE:</p> <p>13 Q. Can you state your name for</p> <p>14 the record, please?</p> <p>15 A. Deborah Bearer.</p> <p>16 Q. Ms. Bearer, my name is Sarah</p> <p>17 Ruane. We met briefly before the</p> <p>18 deposition. I'm here representing the</p> <p>19 plaintiffs.</p> <p>20 And we talked about the fact</p> <p>21 that you actually have laryngitis right</p> <p>22 now; is that correct?</p> <p>23 A. Correct.</p> <p>24 Q. So I apologize in advance.</p>
<p style="text-align: right;">Page 11</p> <p>1 You've been kind enough to still agree to</p> <p>2 move forward with the deposition right</p> <p>3 now. I feel like asking you questions --</p> <p>4 it sounds like it's painful.</p> <p>5 Is it painful for you?</p> <p>6 A. No. No, it just sounds bad.</p> <p>7 Q. Okay. So if there are any</p> <p>8 accommodations we can make that help you,</p> <p>9 just let me know that, all right?</p> <p>10 A. Sure. Thank you.</p> <p>11 Q. We will probably take breaks</p> <p>12 about every hour anyway.</p> <p>13 A. Okay.</p> <p>14 Q. But if you need a break at</p> <p>15 any time, just let me know.</p> <p>16 A. Sure.</p> <p>17 Q. Have you given a deposition</p> <p>18 before?</p> <p>19 A. No.</p> <p>20 Q. A couple of ground rules,</p> <p>21 just to make sure we're all</p> <p>22 communicating, and some of them you may</p> <p>23 have already heard from your attorney.</p> <p>24 But the best way to get a</p>	<p style="text-align: right;">Page 12</p> <p>1 clean record is for me to ask a question,</p> <p>2 full stop, and then you give your answer,</p> <p>3 rather than speak over each other.</p> <p>4 A. Right.</p> <p>5 Q. Do you understand that?</p> <p>6 A. I do.</p> <p>7 Q. And so if any of us start to</p> <p>8 do that, I may do it as well, somebody</p> <p>9 will jump in and let us know. We're not</p> <p>10 trying to be rude, you know, we just want</p> <p>11 to make sure we get a clean record.</p> <p>12 Is that fair?</p> <p>13 A. That's fair.</p> <p>14 Q. Likewise, you understand</p> <p>15 you're under oath today, just like if you</p> <p>16 were before a judge and a jury in a</p> <p>17 courtroom?</p> <p>18 A. Yes.</p> <p>19 Q. And that your testimony can</p> <p>20 be used and played in court?</p> <p>21 A. Correct, I understand.</p> <p>22 Q. And along those lines, my</p> <p>23 goal here today is to make sure I leave</p> <p>24 understanding what you know and what you</p>

1 remember.
 2 So I'm going to try to ask
 3 good questions, but at some point I will
 4 likely ask something that doesn't make
 5 sense to you.
 6 If I do that, will you let
 7 me know?
 8 A. Yes.
 9 Q. And I will try to restate it
 10 and make sure we get on the same page.
 11 But if you answer a question
 12 I've asked, I'll assume you've understood
 13 it; is that fair?
 14 A. That's fair.
 15 Q. Okay. Let's go ahead and
 16 mark as Exhibit-1 your deposition notice.
 17 - - -
 18 (Whereupon, Teva-Bearer
 19 Exhibit-1, No Bates, Notice of
 20 Deposition, was marked for
 21 identification.)
 22 - - -
 23 BY MS. RUANE:
 24 Q. And while I'm doing that,

1 let me ask you, what is your current
 2 address?
 3 A. [REDACTED]
 4 [REDACTED]
 5 Q. And where is Newtown Square?
 6 A. Pennsylvania.
 7 Q. About how far away -- we're
 8 in Philadelphia, right?
 9 A. Sorry, sorry.
 10 It is -- it's a 40-minute
 11 drive. I will say that it's probably 20
 12 miles.
 13 Q. And are you here pursuant to
 14 that Exhibit-1 notice to take your
 15 deposition?
 16 A. Yes.
 17 Q. Are you represented by
 18 counsel today?
 19 A. Yes.
 20 Q. I think Ms. Hillyer is here
 21 acting as your attorney?
 22 A. Yes.
 23 Q. And the attorney for Teva?
 24 A. Yes.

1 Q. Do you currently work for
 2 Teva?
 3 A. Yes.
 4 Q. And what did you do to
 5 prepare for your deposition today?
 6 A. I met with my counsel
 7 yesterday. Since I had not been deposed
 8 prior, it was just to give me some
 9 expectations --
 10 MS. HILLYER: Just make sure
 11 that you don't disclose anything
 12 that we discussed.
 13 THE WITNESS: No, no.
 14 Just expectations for the
 15 day.
 16 BY MS. RUANE:
 17 Q. Got it.
 18 And that's a good point that
 19 Ms. Hillyer made. I don't intend to ask
 20 you anything about what the two of you
 21 discussed.
 22 So if you interpret my
 23 question that way, it's never intended
 24 to --

1 A. Right.
 2 Q. -- to seek that information.
 3 But let me ask you this:
 4 Prior to meeting with Ms. Hillyer, did
 5 you do anything to refresh your memory
 6 about the events in question?
 7 A. No.
 8 Q. When you met with Ms.
 9 Hillyer yesterday, how long did you all
 10 meet?
 11 A. I'll say eight hours.
 12 Q. And was there anyone else
 13 present?
 14 A. Yes.
 15 Q. Were they all attorneys?
 16 A. Yes.
 17 Q. Okay. All attorneys with
 18 Ms. Hillyer's office?
 19 A. Yes.
 20 Q. Got it.
 21 During that meeting, did you
 22 review documents?
 23 A. Yes.
 24 Q. What types of documents do

<p style="text-align: right;">Page 17</p> <p>1 you recall reviewing?</p> <p>2 A. Primarily e-mails and some</p> <p>3 presentations.</p> <p>4 Q. Did you -- were you provided</p> <p>5 a copy or a set of those to take home and</p> <p>6 review?</p> <p>7 A. No.</p> <p>8 Q. And what was, just kind of</p> <p>9 the estimated range of time that those</p> <p>10 e-mails and presentations encompassed?</p> <p>11 A. If I -- I'm not quite sure,</p> <p>12 but I would have to say probably 2003 to</p> <p>13 2014, '15, possibly.</p> <p>14 Q. So it's fair to say that</p> <p>15 within the documents you reviewed</p> <p>16 yesterday, you saw documents referring to</p> <p>17 Actiq and Fentora and likely Vantrela as</p> <p>18 well?</p> <p>19 A. Yes.</p> <p>20 Q. Did you review any</p> <p>21 deposition testimony?</p> <p>22 A. No.</p> <p>23 Q. Did you review any summaries</p> <p>24 of depositions?</p>	<p style="text-align: right;">Page 18</p> <p>1 A. No.</p> <p>2 Q. Okay. Have you spoken with</p> <p>3 anyone at Teva about the testimony</p> <p>4 they've given or the --</p> <p>5 A. No.</p> <p>6 Q. Have you spoken with anybody</p> <p>7 outside of Teva about depositions that</p> <p>8 have occurred in this case, that aren't</p> <p>9 attorneys?</p> <p>10 A. No.</p> <p>11 Q. Okay. Let's back up a</p> <p>12 little bit. I just want to make sure,</p> <p>13 since you and I are meeting for the first</p> <p>14 time, that I have a good understanding of</p> <p>15 your background.</p> <p>16 So I'm going to mark as</p> <p>17 Exhibit-2 a document. This one is really</p> <p>18 just --</p> <p>19 MS. RUANE: For the record,</p> <p>20 it's TEVA_MDL_A_09144727.</p> <p>21 - - -</p> <p>22 (Whereupon, Teva-Bearer</p> <p>23 Exhibit-2, TEVA_MDL_A_09144727,</p> <p>24 was marked for identification.)</p>
<p style="text-align: right;">Page 19</p> <p>1 - - -</p> <p>2 BY MS. RUANE:</p> <p>3 Q. And I'll tell you, it's</p> <p>4 titled, Talent Management Biography.</p> <p>5 It's a document that was in the</p> <p>6 production set that I thought may help us</p> <p>7 kind of more efficiently go through your</p> <p>8 time with Teva and, I guess, potentially</p> <p>9 with Cephalon as well.</p> <p>10 MS. RUANE: You know what,</p> <p>11 I'm sorry, I gave you the wrong</p> <p>12 copy, that's my fault. I should</p> <p>13 have pulled that one out first.</p> <p>14 Becca, would you mind</p> <p>15 putting the sticker on that?</p> <p>16 Thank you.</p> <p>17 MS. HILLYER: I wrote 2 on</p> <p>18 that, but I can cover it up.</p> <p>19 MS. RUANE: Eventually I'll</p> <p>20 get my system figured out.</p> <p>21 MS. HILLYER: It says 2 -- I</p> <p>22 mean, I'm sure this will come off.</p> <p>23 BY MS. RUANE:</p> <p>24 Q. So this is a document that</p>	<p style="text-align: right;">Page 20</p> <p>1 was produced to us in the litigation. If</p> <p>2 you'll turn to Page 2 on it, you'll see,</p> <p>3 is that a picture of you and some</p> <p>4 description?</p> <p>5 A. Yes, it is.</p> <p>6 Q. My first question for you,</p> <p>7 there's a career overview there. And I</p> <p>8 just want to make sure that, to you, that</p> <p>9 looks accurate as far as your time at</p> <p>10 different companies.</p> <p>11 A. Yes.</p> <p>12 Q. Where it says, National</p> <p>13 account manager, was that -- were you</p> <p>14 serving as national account manager at</p> <p>15 that point for Cephalon?</p> <p>16 A. Yes.</p> <p>17 Q. And when did Cephalon become</p> <p>18 Teva?</p> <p>19 A. I believe it was six years</p> <p>20 ago, seven.</p> <p>21 Q. So it's fair to say that</p> <p>22 your time, as well, as the director of</p> <p>23 healthcare systems management, was with</p> <p>24 Cephalon?</p>

<p style="text-align: right;">Page 21</p> <p>1 A. Correct.</p> <p>2 Q. And then you took over as</p> <p>3 the director of healthcare systems</p> <p>4 marketing when it was Cephalon and</p> <p>5 maintained that title after the company</p> <p>6 became Teva?</p> <p>7 A. Yes.</p> <p>8 Q. Okay. Backing up a little</p> <p>9 bit, what's your educational background?</p> <p>10 A. Bachelor of Science degree.</p> <p>11 Q. A Bachelor of Science?</p> <p>12 A. In business management.</p> <p>13 Q. Bachelor of Science in</p> <p>14 business management.</p> <p>15 And then did you start right</p> <p>16 away, after graduation, as a sales rep in</p> <p>17 1983?</p> <p>18 A. No. I had a brief time</p> <p>19 working in retail, commission sales.</p> <p>20 Q. Were those pharmaceutical</p> <p>21 retail?</p> <p>22 A. No, no.</p> <p>23 Q. So was your first time</p> <p>24 working in pharmaceuticals -- well,</p>	<p style="text-align: right;">Page 22</p> <p>1 strike that.</p> <p>2 Let me ask you, when was</p> <p>3 your first time working in</p> <p>4 pharmaceuticals?</p> <p>5 A. 1983.</p> <p>6 Q. Got it.</p> <p>7 And during your time as a</p> <p>8 sales rep there, what were you doing?</p> <p>9 What were you selling?</p> <p>10 A. I was -- we had -- oh, gosh,</p> <p>11 I'm trying to remember how many products,</p> <p>12 a broad spectrum of antibiotics, prenatal</p> <p>13 vitamins, generics.</p> <p>14 It was -- back in those</p> <p>15 days, we carried quite a few products in</p> <p>16 the bag, if you will.</p> <p>17 Q. Did you sell any opioids at</p> <p>18 that time?</p> <p>19 A. No.</p> <p>20 Q. And was it at -- I apologize</p> <p>21 if I'm mispronouncing it, is it</p> <p>22 Sanofi-Aventis, was that the first time</p> <p>23 that you had a role in the managed care</p> <p>24 department?</p>
<p style="text-align: right;">Page 23</p> <p>1 A. No. I'm sorry, wait a</p> <p>2 minute.</p> <p>3 Actually, this is not</p> <p>4 completely correct. At Dupont, when I</p> <p>5 went to Dupont, so I went from Lederle to</p> <p>6 Dupont. Being that this is an internal</p> <p>7 document, this was sort of just --</p> <p>8 Q. Yeah. No worries.</p> <p>9 A. -- a brief abbreviation.</p> <p>10 So I went to Dupont after</p> <p>11 Lederle, and I was a rep. And then while</p> <p>12 I was at Dupont, I did about a year of</p> <p>13 managed care market access. Dupont --</p> <p>14 yes, at Dupont.</p> <p>15 Q. And it looks like, to me,</p> <p>16 you've stayed in the managed care arena</p> <p>17 throughout the rest of your career?</p> <p>18 A. Yes, that's correct. Since</p> <p>19 about 1999 at some point I had a touch</p> <p>20 point with managed care.</p> <p>21 Q. So it's fair to say from</p> <p>22 1999 to today, your primary focus of</p> <p>23 employment is managed care?</p> <p>24 A. Correct.</p>	<p style="text-align: right;">Page 24</p> <p>1 Q. And managed care -- well,</p> <p>2 strike that.</p> <p>3 Let me ask this: Can you</p> <p>4 describe for the jury what managed care</p> <p>5 is?</p> <p>6 A. So the words are</p> <p>7 interchangeable between market access and</p> <p>8 managed care, because there's been an</p> <p>9 evolution over time as to what that</p> <p>10 actually is.</p> <p>11 But, basically, what it</p> <p>12 involves is insurance companies taking</p> <p>13 ownership and responsibility or financial</p> <p>14 risk on behalf of the patient or the</p> <p>15 employee for the employer.</p> <p>16 So, for example, Aetna</p> <p>17 gathers its medical benefits, pharmacy</p> <p>18 benefits, so there are probably over 100</p> <p>19 managed care organizations in the U.S.</p> <p>20 This continues to evolve over time.</p> <p>21 During that time, they make</p> <p>22 formulary decisions around the access for</p> <p>23 pharmaceuticals that an employee may</p> <p>24 have. So if a physician prescribes a</p>

<p style="text-align: right;">Page 25</p> <p>1 medication that's not available, say, 2 through Aetna as your pharmacy, then 3 oftentimes it will be denied and other 4 products will be recommended. 5 That's just a very 6 simplified version. 7 Q. That's helpful. And I 8 appreciate it. 9 So during your time -- well, 10 let me ask this first. 11 When you moved over to 12 Cephalon -- 13 A. Yes. 14 Q. -- as a national account 15 manager -- 16 A. Yes. 17 Q. -- was that still in the 18 managed care arena? 19 A. That is national -- so 20 national account managers are regional 21 account managers for pharmaceuticals with 22 reference to the CLI, calling on managed 23 care organizations, either PBMs, pharmacy 24 benefit managers, or managed care HMOs,</p>	<p style="text-align: right;">Page 26</p> <p>1 things of that nature. Not unlike a 2 sales rep would call on a physician. 3 So it's basically a selling, 4 promoting -- it's a promotional activity. 5 It falls under commercial. 6 Q. Got it. Okay. 7 And so at the time that you 8 moved over to Cephalon in 2003, you were 9 doing promotion to managed care entities? 10 A. Correct. 11 Q. And in -- am I right that in 12 2003, then, one of the drugs that you 13 would have been promoting to managed care 14 facilities would have been Actiq? 15 A. Correct. 16 Q. And, of course, over time is 17 it -- am I right that it's the kind of 18 2007-2008 time frame, then, when you all 19 would have started promoting Fentora to 20 managed care facilities? 21 A. When it was launched it's my 22 understanding it was 2007. I'm not 100 23 percent certain. It seems correct. 24 Q. And that's fair. So I</p>
<p style="text-align: right;">Page 27</p> <p>1 should have -- let me ask a better 2 question. 3 We can look up precisely 4 when it was launched, but around that 5 time frame -- 6 A. Yes. 7 Q. -- whenever it was launched, 8 then, the role of the managed care team 9 was to promote Fentora, amongst others, 10 to the managed care entities? 11 MS. HILLYER: Objection to 12 form. 13 You can answer. 14 THE WITNESS: What? 15 MS. HILLYER: You can 16 answer. 17 THE WITNESS: That's -- I 18 want to clarify something. 19 In 2007, I was not in a 20 payer-facing, customer-facing 21 role. 22 BY MS. RUANE: 23 Q. Thank you. And that's a 24 good distinction. So let's clarify that.</p>	<p style="text-align: right;">Page 28</p> <p>1 In 2005, you moved over and 2 became the director of healthcare systems 3 management? 4 A. Yes. 5 Q. And so -- and was that a 6 supervisory role over national account 7 managers? 8 A. No, no. That was moving 9 into a home office type of position 10 working with the brand teams, not just 11 for this product but others as well, on 12 the strategy and some of the tactics for 13 each of the products as related to 14 reimbursement. 15 Q. Got it. So let me try to 16 ask a better question, then. 17 A. Okay. 18 Q. In your role, then, from 19 2007, or whenever Fentora launched, in 20 your role as director of healthcare 21 systems, one of your responsibilities 22 would have been to weigh in on strategy 23 and tactics to improve reimbursement of 24 the drug Fentora?</p>

<p style="text-align: right;">Page 29</p> <p>1 A. That's correct.</p> <p>2 Q. And one way to do that is to</p> <p>3 help managed care entities understand,</p> <p>4 from your perspective and from the</p> <p>5 company's perspective, that a broader</p> <p>6 group of indications for prior</p> <p>7 authorization would be useful and</p> <p>8 appropriate?</p> <p>9 MS. HILLYER: Objection to</p> <p>10 form.</p> <p>11 You can answer if you</p> <p>12 understand.</p> <p>13 THE WITNESS: Could you</p> <p>14 rephrase it a little bit? Because</p> <p>15 I --</p> <p>16 BY MS. RUANE:</p> <p>17 Q. Yes. This is perfect.</p> <p>18 You're doing the right thing. This is</p> <p>19 what's going to happen, I'm going to ask</p> <p>20 bad questions, because I'm in my own</p> <p>21 head, and I'll rephrase them and we'll</p> <p>22 get through it together. So let me ask</p> <p>23 this differently.</p> <p>24 What was the change in your</p>	<p style="text-align: right;">Page 30</p> <p>1 role after -- from director of healthcare</p> <p>2 systems management to director of</p> <p>3 healthcare systems marketing?</p> <p>4 A. Okay. You're right. When I</p> <p>5 was director of healthcare systems</p> <p>6 management, I managed -- I need to</p> <p>7 correct something I said earlier, my</p> <p>8 timeline here.</p> <p>9 As the director of</p> <p>10 healthcare systems management, I was</p> <p>11 managing six account managers, and they</p> <p>12 called on the payers.</p> <p>13 When I moved into the</p> <p>14 healthcare systems marketing, that's when</p> <p>15 I became a home office. So I apologize</p> <p>16 for that.</p> <p>17 The home office position,</p> <p>18 which -- to state what I stated earlier,</p> <p>19 worked with the brand team, looked at the</p> <p>20 strategies related to reimbursement; not</p> <p>21 only reimbursement in talking with</p> <p>22 payers, but also reimbursement support</p> <p>23 services for patients, et cetera.</p> <p>24 Q. Got it. Okay. That's</p>
<p style="text-align: right;">Page 31</p> <p>1 helpful. And I appreciate that</p> <p>2 distinction.</p> <p>3 And so during the time from</p> <p>4 2005 to 2007 --</p> <p>5 A. Yes.</p> <p>6 Q. -- when you were supervising</p> <p>7 six account managers --</p> <p>8 A. Correct.</p> <p>9 Q. -- those account managers</p> <p>10 would have been calling on managed care</p> <p>11 entities --</p> <p>12 A. Correct.</p> <p>13 Q. -- to promote Actiq and</p> <p>14 then, once the launch date occurred, to</p> <p>15 promote Fentora?</p> <p>16 A. That's correct.</p> <p>17 Q. Okay. On that same sheet,</p> <p>18 if you look under current</p> <p>19 responsibilities, the first bullet point</p> <p>20 indicates that you provide market access,</p> <p>21 marketing support and strategic planning.</p> <p>22 A. Yes.</p> <p>23 Q. Is that kind of what we've</p> <p>24 been discussing before --</p>	<p style="text-align: right;">Page 32</p> <p>1 A. That's what we've been</p> <p>2 talking about.</p> <p>3 MS. HILLYER: Make sure she</p> <p>4 finishes the question.</p> <p>5 THE WITNESS: I apologize.</p> <p>6 MS. HILLYER: That's okay.</p> <p>7 MS. RUANE: It's okay.</p> <p>8 THE WITNESS: It was 20</p> <p>9 minutes before I did that. Sorry.</p> <p>10 BY MS. RUANE:</p> <p>11 Q. So the market access,</p> <p>12 marketing support and strategic planning</p> <p>13 is kind of that brand team strategy and</p> <p>14 tactics that you've been discussing?</p> <p>15 A. Yes.</p> <p>16 Q. And you did that for the</p> <p>17 Fentora product?</p> <p>18 A. Yes.</p> <p>19 Q. And the second bullet point</p> <p>20 indicates that you lead cross-functional</p> <p>21 market access for the Vantrela launch</p> <p>22 teams?</p> <p>23 A. Yes.</p> <p>24 Q. Can you explain to me what</p>

1 that means?

2 A. In preparation for the
3 launch, the brand team, the commercial
4 team, has various subteams that feed into
5 the overarching brand strategy.

6 So market access is one of
7 them. You would have, say,
8 direct-to-consumer, you would have HCP
9 and you would have market access, you
10 might have sales and distribution.

11 So I led that functional
12 subteam supporting the development of the
13 payer strategy for the launch of
14 Vantrela.

15 Q. Got it. For the launch of
16 Vantrela.

17 And on the fourth bullet
18 point there, it indicates that you
19 develop and manage reimbursement support
20 programs.

21 A. Yes.

22 Q. What are the reimbursement
23 support programs?

24 A. And this was a

1 collaboration, by the way. Most of these
2 things are -- you know, are in a matrix
3 organization at Teva, so.

4 Reimbursement support
5 programs, there's a patient assistance
6 program, which is not under my purview,
7 but it is something that I have knowledge
8 of when it comes to the overarching
9 reimbursement and assistance for
10 patients.

11 There's also the
12 reimbursement hotline, which is for
13 patients and physicians. And I helped
14 facilitate -- there's a vendor, of
15 course, a third party that handles that.
16 So I'm the liaison between the brand,
17 those services, and being, more or less,
18 the content expert for market access and
19 reimbursement.

20 Q. So it sounds like if there
21 are questions or concerns about the
22 hotline, they would be referred to you as
23 the --

24 A. Yeah, as the --

1 MS. HILLYER: Just let her
2 finish.

3 MS. RUANE: Sorry. I have a
4 tendency in my questions to trail
5 off as I'm thinking. So that's
6 not your fault, that's my fault.
7 I'll try to fix it.

8 THE WITNESS: That's okay.

9 BY MS. RUANE:

10 Q. Let me restate it.

11 So it's fair to say that if
12 there were questions or concerns about
13 the hotline program, that they would be
14 referred to you as kind of the leader of
15 that entity?

16 A. Yes. As with any company,
17 though, obviously, roles and
18 responsibilities often shift a bit.

19 The brand has a lot of
20 responsibility as well, you know. So
21 we're a support system for the marketing
22 team, the brand team.

23 Q. And you work pretty closely
24 with the marketing team and brand team?

1 A. Yes.

2 Q. Are some of the individuals
3 on those teams that you work with Matt
4 Day and Randy Spokane, or am I getting my
5 teams mixed up?

6 A. Can you --

7 MS. HILLYER: Objection to
8 form. When are you talking about?

9 MS. RUANE: That's a good
10 point.

11 MS. HILLYER: And which
12 product?

13 BY MS. RUANE:

14 Q. Let's see. Since you've
15 been there since 2003 and we're sitting
16 here in 2018, it's fair to say that over
17 time your roles changed and other
18 people's roles have changed?

19 A. Correct.

20 Q. During the time that Actiq
21 was being promoted to managed care
22 entities, did you have interactions with
23 people like Matt Day and Randy Spokane?

24 MS. HILLYER: Objection to

1 form.
2 You can answer.
3 THE WITNESS: What do you
4 mean "interactions"? Can you
5 clarify what you mean,
6 "interactions"?
7 BY MS. RUANE:
8 Q. Sure.
9 You mentioned you work
10 closely with the marketing and brand
11 teams.
12 A. Yes.
13 Q. Would that have been
14 something that you would have done during
15 that time that Actiq was being promoted
16 to managed care entities?
17 A. No. Because marketing -- I
18 was in the field, at that time with
19 Actiq, and I was an account manager.
20 Now, I -- and, by the way,
21 Randy Spokane is not marketing, he's
22 sales. And, yes, I did work with Randy
23 Spokane.
24 Q. Got it.

1 15th, 2007.
2 MS. RUANE: And, for the
3 record, this is
4 TEVA_MDL_A_00873333 through 3335.
5 BY MS. RUANE:
6 Q. A lot of this we've already
7 talked about.
8 Under objectives and
9 accomplishments, you identify the fact
10 that you're implementing managed care and
11 reimbursement strategy and tactics for
12 optimizing access for all Cephalon
13 products.
14 Is that consistent with what
15 we talked about, as far as the goal to
16 optimize access to Actiq during the time
17 frame it was involved, and then Fentora?
18 MS. HILLYER: Hold on a
19 second.
20 Objection to form.
21 But you can answer. And
22 take your time to look through it
23 if you need to.
24 THE WITNESS: I'd like you

1 A. Matt Day was in the home
2 office.
3 MS. RUANE: I'm going to go
4 ahead and mark as Exhibit-3 an
5 employee self-appraisal.
6 MS. HILLYER: Are we done
7 with 2?
8 MS. RUANE: Yes.
9 - - -
10 (Whereupon, Teva-Bearer
11 Exhibit-3,
12 TEVA_MDL_A_00873333-335, was
13 marked for identification.)
14 - - -
15 BY MS. RUANE:
16 Q. And I know how people love
17 to fill out self-appraisals, so I thought
18 maybe sitting here, 11 years later, we
19 would talk about it again.
20 But I really actually just
21 pulled it because I think it's a good way
22 for us to just review a couple of the
23 things you were doing around that time.
24 So this is dated October

1 to restate it for me, please.
2 BY MS. RUANE:
3 Q. Sure.
4 We talked about the fact,
5 one of the goals of your role as a -- I
6 guess at this point you would have been a
7 director of healthcare systems marketing,
8 right?
9 A. Yeah -- no. Let me just
10 make sure. Hold on.
11 Q. I guess it's the year you
12 switched over, so --
13 A. Yeah, probably. Because it
14 mentions that I also managed. So I was
15 probably transitioning. I don't really
16 remember, to be honest with you.
17 Q. Okay. In any event, by
18 October of 2007, one of the things that
19 you defined as an objective and
20 accomplishment was implementing -- and
21 this is just part of that line right
22 under it -- implementing managed care and
23 reimbursement strategy and tactics for
24 optimizing access for all Cephalon

<p style="text-align: right;">Page 41</p> <p>1 products?</p> <p>2 A. Yes.</p> <p>3 Q. And down below, you kind of</p> <p>4 call out, in a bullet point, Fentora as</p> <p>5 one of the products that you're tasked</p> <p>6 with optimizing access to, correct?</p> <p>7 A. Correct.</p> <p>8 Q. And you include there, in a</p> <p>9 couple of the bullet points, the things</p> <p>10 that you're doing as it relates to</p> <p>11 Fentora.</p> <p>12 One of those is, like we</p> <p>13 talked about, optimizing access and</p> <p>14 reducing barriers; is that correct?</p> <p>15 A. Yes.</p> <p>16 Q. The last bullet point under</p> <p>17 Fentora indicates, Maintained access, 90</p> <p>18 percent target accounts.</p> <p>19 MS. HILLYER: Where are you?</p> <p>20 MS. RUANE: I'm sorry. The</p> <p>21 last bullet point under Fentora.</p> <p>22 The top of 34.</p> <p>23 BY MS. RUANE:</p> <p>24 Q. Can you explain to me what</p>	<p style="text-align: right;">Page 42</p> <p>1 that's referring to?</p> <p>2 A. I need to define access for</p> <p>3 you, because there's different levels of</p> <p>4 access. It means the patient -- the</p> <p>5 prescription is prescribed, there may be</p> <p>6 paperwork involved, et cetera, but at the</p> <p>7 end of the day, the patient has access to</p> <p>8 the product.</p> <p>9 Sometimes a prescription can</p> <p>10 be written and it just goes to the</p> <p>11 pharmacy and you walk away. Other times,</p> <p>12 there's more hurdles involved.</p> <p>13 So what this means is that</p> <p>14 of the target accounts, this would be</p> <p>15 referring to when I was managing the</p> <p>16 account management team, which were those</p> <p>17 six account managers, and what we were --</p> <p>18 we identified target accounts. And of</p> <p>19 those targets, we wanted to ensure that</p> <p>20 patients have access to Fentora.</p> <p>21 Q. And so how did you identify</p> <p>22 target accounts?</p> <p>23 A. There's many ways in which</p> <p>24 this is done. Oftentimes, it's done in</p>
<p style="text-align: right;">Page 43</p> <p>1 collaboration with the home office</p> <p>2 marketing team, where you look at the</p> <p>3 number of covered lives, the geographic</p> <p>4 footprint, there's -- an example might be</p> <p>5 in Pittsburgh, Highmark is one of the</p> <p>6 target accounts. It influences a lot of</p> <p>7 prescriber behavior, because many</p> <p>8 patients are enrolled in Highmark.</p> <p>9 So there is a strategy --</p> <p>10 there is a method to identifying. Most</p> <p>11 often, it really is related, though, to</p> <p>12 where the most number of commercial</p> <p>13 covered lives are.</p> <p>14 Sorry, I'm trailing off.</p> <p>15 Many times, it's obviously</p> <p>16 based on enrollment, the larger the plan,</p> <p>17 the more patients they have. They become</p> <p>18 a target.</p> <p>19 Q. And so you mentioned</p> <p>20 Highmark as an example in the Pittsburgh</p> <p>21 area.</p> <p>22 But when you would identify</p> <p>23 managed care entities who had a large</p> <p>24 enough either geographic footprint or,</p>	<p style="text-align: right;">Page 44</p> <p>1 you know -- what did you say about lives?</p> <p>2 I want to make sure I use the right term.</p> <p>3 A. Covered lives.</p> <p>4 Q. Covered lives.</p> <p>5 A. Think of it as enrollment,</p> <p>6 same thing, covered lives.</p> <p>7 Q. So, basically, the largest</p> <p>8 numbers of enrollment or covered lives</p> <p>9 are going to be targets because there's</p> <p>10 quite a few people who, potentially,</p> <p>11 could receive access to a drug like</p> <p>12 Fentora, for example?</p> <p>13 MS. HILLYER: Objection to</p> <p>14 form.</p> <p>15 You can answer.</p> <p>16 THE WITNESS: My answer is</p> <p>17 that that's true of any drug,</p> <p>18 correct.</p> <p>19 BY MS. RUANE:</p> <p>20 Q. And the way that the managed</p> <p>21 care team worked on maintaining access to</p> <p>22 those drugs is kind of detailed in the</p> <p>23 strategy and tactics for reimbursement</p> <p>24 that you were involved in?</p>

<p style="text-align: right;">Page 45</p> <p>1 MS. HILLYER: Objection to</p> <p>2 form. What strategies and tactics</p> <p>3 are you referring to?</p> <p>4 MS. RUANE: Let me rephrase</p> <p>5 that question.</p> <p>6 BY MS. RUANE:</p> <p>7 Q. We talked about, for</p> <p>8 example, reimbursement support programs</p> <p>9 like hot lines, correct?</p> <p>10 A. Yes.</p> <p>11 Q. Would those be one form of</p> <p>12 maintaining access?</p> <p>13 A. No.</p> <p>14 Q. Okay. So what would be</p> <p>15 forms of maintaining access? What do you</p> <p>16 do?</p> <p>17 A. You call on -- so you</p> <p>18 provide -- you determine, say, a payer,</p> <p>19 the account manager goes in, speaks to</p> <p>20 the plan, provides the clinical</p> <p>21 information about the product.</p> <p>22 The plan can request</p> <p>23 additional information. They can request</p> <p>24 information that's non-promotional</p>	<p style="text-align: right;">Page 46</p> <p>1 through a medical information request</p> <p>2 form. Basically, it's negotiating the</p> <p>3 unmet need -- the benefits of the product</p> <p>4 and working with the plan to ensure that</p> <p>5 patients -- that they place it on the</p> <p>6 formulary so that patients, appropriate</p> <p>7 patients, have access.</p> <p>8 Q. Is it correct that the</p> <p>9 ultimate goal is to have the medication</p> <p>10 placed on the formulary?</p> <p>11 A. Yes. The alternative is</p> <p>12 it's blocked.</p> <p>13 Q. What is the difference</p> <p>14 between -- I've also seen reference to</p> <p>15 prior authorization --</p> <p>16 A. Yep.</p> <p>17 Q. -- and appeals and letters</p> <p>18 of medical necessity.</p> <p>19 And I'm going to ask you</p> <p>20 some questions about that in a little</p> <p>21 bit.</p> <p>22 A. Okay.</p> <p>23 Q. My first question is, what</p> <p>24 is the distinction between a drug being</p>
<p style="text-align: right;">Page 47</p> <p>1 placed on a formulary and a drug</p> <p>2 receiving prior authorization?</p> <p>3 MS. HILLYER: Objection.</p> <p>4 That's kind of broad.</p> <p>5 But you can answer if you</p> <p>6 can briefly.</p> <p>7 THE WITNESS: I can answer</p> <p>8 it?</p> <p>9 So in order to -- the goal</p> <p>10 is to get the drug placed on</p> <p>11 formulary, that's the first step.</p> <p>12 There are other things that</p> <p>13 I'll talk about, if you need more</p> <p>14 detail. But the -- to answer your</p> <p>15 question on prior authorization,</p> <p>16 once the product is on formulary,</p> <p>17 the plan may determine a prior</p> <p>18 authorization is required, that</p> <p>19 the physician fills out, based on</p> <p>20 the criteria the plans deem</p> <p>21 appropriate for covering that</p> <p>22 drug.</p> <p>23 It's an administrative</p> <p>24 effort, most of the time, where</p>	<p style="text-align: right;">Page 48</p> <p>1 the doc fills out the form, it's</p> <p>2 reviewed by the plan, they</p> <p>3 determine whether it's covered or</p> <p>4 not; they either say yes or no.</p> <p>5 And then if it's yes, the</p> <p>6 patient has access to the product;</p> <p>7 if the answer is no, a physician</p> <p>8 can appeal.</p> <p>9 BY MS. RUANE:</p> <p>10 Q. Thank you. I appreciate</p> <p>11 that.</p> <p>12 I also wanted to ask, the</p> <p>13 bullet point just above that indicates,</p> <p>14 Collaboration and communication with</p> <p>15 sales teams to identify KOLs.</p> <p>16 What are KOLs?</p> <p>17 A. Key opinion leaders,</p> <p>18 physicians.</p> <p>19 Q. And did the brand -- strike</p> <p>20 that.</p> <p>21 Did the managed care team</p> <p>22 utilize key opinion leaders?</p> <p>23 MS. HILLYER: Objection to</p> <p>24 form.</p>

1 BY MS. RUANE:
 2 Q. As it relates to Actiq
 3 and/or Fentora?
 4 A. Define "utilize."
 5 Q. Did the managed care team
 6 have key opinion leaders that spoke to
 7 managed care entities?
 8 A. There was a managed care
 9 speaker bureau of which, if a plan
 10 requested a clinical presentation or a
 11 presentation from a clinician, typically
 12 those would be considered KOLs. So, yes.
 13 In a limited fashion, but yes.
 14 Q. So Teva maintained a managed
 15 care speaker bureau, which was kind of a
 16 database of key opinion leaders who, at
 17 the request of a managed care entity,
 18 could be brought in to speak to that
 19 entity; am I understanding that
 20 correctly?
 21 A. That's correct.
 22 MS. HILLYER: Objection to
 23 form.
 24 Go ahead.

1 Q. Any names.
 2 Do any names come to mind?
 3 A. One name comes to mind, Jeff
 4 Gudin.
 5 Q. And were you personally
 6 involved in establishing or setting up
 7 those key opinion leaders to go in and
 8 speak?
 9 A. I was aware. I don't recall
 10 being a facilitator of it.
 11 Q. What about during the time
 12 that managed care entities were being
 13 called on to promote Actiq, are you --
 14 just sitting here today, do you have a
 15 memory of the names of any of the key
 16 opinion leaders who spoke to managed care
 17 entities?
 18 A. During that time, I don't
 19 believe any did, that the speaker bureau
 20 that we're referring to came later.
 21 So that's why the timing of
 22 your question is important. There's been
 23 an evolution.
 24 Q. Thank you.

1 BY MS. RUANE:
 2 Q. Am I understanding that
 3 correctly?
 4 A. Restate it, because I --
 5 Q. Sure.
 6 So Teva maintains a managed
 7 care speaker bureau of key opinion
 8 leaders that they identified. And at the
 9 request of a managed care entity, Teva
 10 would facilitate one of those key opinion
 11 leaders to come in and speak to the
 12 managed care entity?
 13 A. Yes.
 14 Q. Okay. Were you involved --
 15 like sitting here right now, offhand, do
 16 you know the names of the key opinion
 17 leaders that would speak?
 18 MS. HILLYER: Objection to
 19 form. When and which product?
 20 And which entity?
 21 MS. RUANE: Thank you.
 22 BY MS. RUANE:
 23 Q. With Fentora.
 24 A. Any names?

1 So if I'm understanding
 2 correctly, the managed care speaker
 3 bureau is something that applied to the
 4 time frame after Fentora was launched?
 5 A. To the best of my
 6 recollection, yes.
 7 Q. And when -- if you know,
 8 when key opinion leaders were brought in
 9 to speak to managed care entities, were
 10 they compensated by Teva?
 11 A. Yes.
 12 Q. When -- whether it's the key
 13 opinion leader or just a representative
 14 from Teva calling on managed care
 15 entities, who were the individuals in the
 16 managed care entities who were present at
 17 those meetings? What roles?
 18 MS. HILLYER: Objection to
 19 form. That's compound. You're
 20 asking two different scenarios.
 21 And it's confusing, because key
 22 opinion leaders didn't call on
 23 managed care.
 24 MS. RUANE: Let me divide

<p style="text-align: right;">Page 53</p> <p>1 them up.</p> <p>2 BY MS. RUANE:</p> <p>3 Q. When key opinion leaders</p> <p>4 would come in to speak to managed care</p> <p>5 entities, as facilitated by Teva, who</p> <p>6 would be in the audience, if you know?</p> <p>7 A. Typically, it would be a</p> <p>8 pharmacy director, a pharmacy -- clinical</p> <p>9 pharmacists and medical directors.</p> <p>10 Q. And when Teva employees</p> <p>11 would simply call on managed care</p> <p>12 entities in order to explain and try to</p> <p>13 maintain access to their products, who</p> <p>14 would be in the audience, typically, if</p> <p>15 you know?</p> <p>16 A. Pharmacy directors. Some</p> <p>17 plans have trade pharmacy contracting.</p> <p>18 So you have pharmacy and then there would</p> <p>19 be a contracting arm as well,</p> <p>20 potentially. And, occasionally, clinical</p> <p>21 pharmacists. Same audience.</p> <p>22 Q. Would the medical directors</p> <p>23 be present at those as well?</p> <p>24 A. That's a broad question.</p>	<p style="text-align: right;">Page 54</p> <p>1 Sometimes, I guess, the answer would be.</p> <p>2 Q. And, I guess, I kind of</p> <p>3 assumed this in my question, but I should</p> <p>4 clarify, just to point out, the managed</p> <p>5 care entities, we're talking about them</p> <p>6 as entities, but, obviously, they have</p> <p>7 employees, some of whom are physicians</p> <p>8 and some of whom are pharmacists, in your</p> <p>9 experience?</p> <p>10 A. They have both. And in</p> <p>11 addition to a number of other</p> <p>12 responsible -- you know, employees.</p> <p>13 Q. And the reason I ask is just</p> <p>14 because I think some people hear managed</p> <p>15 care entity and they assume it's just a</p> <p>16 whole bunch of business people.</p> <p>17 So in your experience in the</p> <p>18 managed care entities that you've called</p> <p>19 on and that you've supervised people</p> <p>20 calling on, the managed care entities,</p> <p>21 the decision-makers include physicians</p> <p>22 and pharmacists as well, correct?</p> <p>23 A. Correct.</p> <p>24 Q. Okay. And it's fair to say,</p>
<p style="text-align: right;">Page 55</p> <p>1 when you were involved in marketing and</p> <p>2 promoting products like Fentora, that</p> <p>3 marketing and promotion was going to --</p> <p>4 in part, to physicians and pharmacists</p> <p>5 employed by those managed care entities?</p> <p>6 MS. HILLYER: Objection to</p> <p>7 the form.</p> <p>8 You can answer if you</p> <p>9 understand.</p> <p>10 THE WITNESS: Just clarify</p> <p>11 for me, if you would --</p> <p>12 BY MS. RUANE:</p> <p>13 Q. Sure.</p> <p>14 A. -- what you're asking.</p> <p>15 Q. As an example, we've talked</p> <p>16 about the fact that you all might come up</p> <p>17 with, you know, a new presentation to</p> <p>18 give to a managed care entity.</p> <p>19 And when you go in to give</p> <p>20 that presentation, people in the audience</p> <p>21 included physicians and pharmacists,</p> <p>22 correct?</p> <p>23 A. They could, yes.</p> <p>24 Q. They could.</p>	<p style="text-align: right;">Page 56</p> <p>1 That was generally your</p> <p>2 experience? I mean, I get every audience</p> <p>3 is different. But, generally speaking,</p> <p>4 that was your experience?</p> <p>5 MS. HILLYER: Objection to</p> <p>6 form.</p> <p>7 BY MS. RUANE:</p> <p>8 Q. Am I correct?</p> <p>9 A. Generally. I would say --</p> <p>10 if you're asking me to be general, I</p> <p>11 would say the majority of times the</p> <p>12 medical directors were not present, but</p> <p>13 they could be.</p> <p>14 Q. And are the medical</p> <p>15 directors -- if you know, are the medical</p> <p>16 directors the ultimate determinate of</p> <p>17 prior authorization?</p> <p>18 MS. HILLYER: Objection.</p> <p>19 Calls for speculation.</p> <p>20 THE WITNESS: I don't know.</p> <p>21 BY MS. RUANE:</p> <p>22 Q. Okay. Just a couple quick</p> <p>23 things, and then we'll move on.</p> <p>24 On Page 35, so the last page</p>

1 of Exhibit-3, under, Fentora brand
 2 team --
 3 MS. HILLYER: She's talking
 4 about these, 35.
 5 THE WITNESS: Oh, I see.
 6 BY MS. RUANE:
 7 Q. -- it indicates that you
 8 participated in the managed care working
 9 group for the FAST team, 2008 brand
 10 strategy.
 11 A. Yes.
 12 Q. Can you describe for me what
 13 that is?
 14 A. I hadn't seen it in a while.
 15 I think it was just an acronym for the
 16 Fentora action strategic something or
 17 other.
 18 It was just -- you know,
 19 these are marketing people, they like to
 20 name things. But, basically, it was the
 21 brand strategy team.
 22 Q. There's a lot of marketing
 23 lingo. So I appreciate you know some of
 24 it, because it's taken me a while to

1 Q. And so prior to Fentora, was
 2 there an Actiq dossier or was this a new
 3 way of marketing?
 4 MS. HILLYER: Let her
 5 finish.
 6 THE WITNESS: I was going to
 7 cough.
 8 MS. HILLYER: I thought you
 9 were about to answer.
 10 THE WITNESS: No, no.
 11 To the best of my
 12 recollection, there was not one
 13 for Actiq. This -- as we talked,
 14 there's an evolution through
 15 managed care. Dossiers became
 16 more recognized by plans during
 17 this time.
 18 So it's, basically, an AMCP,
 19 Academy of Managed Care Pharmacy,
 20 dossier format.
 21 And often a company -- now
 22 they're electronic, all pharma
 23 companies typically, when they're
 24 launching a product, provide a

1 learn some of these.
 2 So the FAST team was kind of
 3 one of the names that marketing gave the
 4 Fentora launch?
 5 A. As I recall. And as I
 6 described earlier, the working group was
 7 the subteam that I referred to.
 8 Q. Got it.
 9 And you also participated --
 10 as a result of being part of that Fentora
 11 brand team, you participated in the
 12 development and review of the Fentora
 13 dossier and NAM slide deck?
 14 A. Yes.
 15 That would be the NAM,
 16 national account manager, just so you
 17 know.
 18 Q. So that was my question. Is
 19 the national account manager -- well,
 20 strike that. Let me ask this first.
 21 The Fentora dossier and the
 22 NAM slide deck, are those specific to
 23 managed care?
 24 A. Yes.

1 dossier, upon request, to a plan.
 2 BY MS. RUANE:
 3 Q. You mentioned the -- are you
 4 okay?
 5 A. Yes.
 6 Q. Just let me know if you need
 7 a break.
 8 A. I will. I'm not shy.
 9 Q. You mentioned in there AMCP.
 10 What's AMCP?
 11 A. Academy of Managed Care
 12 Pharmacy. It's an organization, like
 13 some of the others, that have membership
 14 of all the managed care companies,
 15 individual membership.
 16 They are like a so-called
 17 overseer. They have a journal they
 18 produce. They have a large meeting twice
 19 a year for pharmacy students. It's not
 20 unlike some of the other professional
 21 organizations.
 22 Q. Are you a member of that
 23 professional organization?
 24 A. No.

1 Q. So the -- it sounds like
2 with Fentora -- because of the shift as
3 you described, with Fentora, a dossier
4 and a NAM slide deck was created that
5 would be provided, upon request, to the
6 managed care entities?

7 A. No. The dossier, yes.

8 The NAM slide deck is a
9 promotional piece, not unlike a sales
10 aid, that the account manager would use
11 in presenting or talking with a health
12 plan, a payer.

13 Q. Got it. I feel like it's
14 catching.

15 So thank you. Let me ask
16 this question again, just to make sure
17 we're clear, and then we'll move on.

18 So the dossier would be
19 provided, upon request, to the managed
20 care entity. The NAM slide deck was
21 something that was simply used during
22 presentations to managed care entities
23 from a Teva employee?

24 MS. HILLYER: Objection to

1 form.

2 You can answer.

3 THE WITNESS: Is that
4 because it's compound?

5 MS. HILLYER: Yes.

6 BY MS. RUANE:

7 Q. I can divide them up --

8 A. That's okay.

9 Q. -- if it makes you feel
10 better.

11 A. The dossier was upon
12 request. The NAM presentation was as you
13 stated.

14 Q. Got it.

15 And you participated in the
16 development of those documents, according
17 to --

18 A. Yes, it says that. But the
19 dossier is typically developed under the
20 medical team.

21 The only thing that I would
22 say to that, it's probably incorrectly
23 referenced, is it's a compilation of
24 study -- clinical data, any health

1 economics data, et cetera. It's not a
2 promotional piece.

3 I was privy to what was
4 included in the dossier. This NAM slide
5 deck is a promotional piece.

6 Q. And so dividing them up, you
7 were privy to the information that was
8 contained in the Fentora dossier?

9 A. Yes.

10 Q. And you were also -- and am
11 I understanding you correctly that your
12 memory is you did not actually
13 participate in the development of the
14 dossier --

15 A. No.

16 Q. -- you just knew what was in
17 it because you were on the e-mails?

18 A. Yes.

19 Q. Got it.

20 With the NAM slide deck, you
21 did participate in the development of the
22 NAM slide deck, correct?

23 A. As I recall, yes.

24 Q. Let's move on -- actually,

1 before we do, a couple of things I just
2 want to make sure.

3 I've asked several questions
4 of you already about kind of marketing
5 terms or things that I don't understand
6 within this, and you've been kind enough
7 to define them so far.

8 There's a couple of other
9 things I want to make sure we're on the
10 same page about.

11 Do you agree that during the
12 time -- well, actually, the entire time
13 that Actiq was being sold that the
14 indication for Actiq was for breakthrough
15 pain in cancer patients?

16 A. That's the label.

17 Q. And I guess the full title
18 would be, For breakthrough pain in cancer
19 patients who are opioid tolerant,
20 correct?

21 A. Correct.

22 Q. Okay. And that was true the
23 entire time that Actiq was being sold,
24 correct?

1 A. Correct.
 2 Q. Do you also agree that the
 3 indication for Fentora was for
 4 breakthrough cancer pain in patients who
 5 are opioid tolerant?
 6 A. Cancer pain, yes.
 7 Q. For breakthrough cancer
 8 pain, correct?
 9 A. Yes.
 10 Q. And so you understood that
 11 it was illegal to market or promote those
 12 products off label?
 13 MS. HILLYER: Objection.
 14 Calls for a legal conclusion.
 15 MS. RUANE: You can answer.
 16 THE WITNESS: I'm not an
 17 attorney.
 18 BY MS. RUANE:
 19 Q. In your role working with
 20 managed care entities, you had an
 21 understanding about what on label was,
 22 correct? We just talked about it.
 23 MS. HILLYER: Objection to
 24 form.

1 Q. And you --
 2 A. Sorry.
 3 Q. Sorry?
 4 A. Correct.
 5 Q. And you understood, in your
 6 role with both Cephalon and Teva, that it
 7 would be illegal to market or promote the
 8 use of Actiq and Fentora for anything
 9 other than on-label use?
 10 MS. HILLYER: Objection.
 11 Asked and answered. And calls for
 12 a legal conclusion.
 13 MS. RUANE: You can answer.
 14 THE WITNESS: Say it again.
 15 Sorry.
 16 BY MS. RUANE:
 17 Q. Sure.
 18 You understood --
 19 A. Right.
 20 Q. -- during the time that
 21 you've been employed by Cephalon and then
 22 Teva --
 23 A. Right.
 24 Q. -- that it is illegal to

1 But you can answer.
 2 THE WITNESS: I understand
 3 what the label -- I understand
 4 what the indication in the label
 5 stated, yes.
 6 BY MS. RUANE:
 7 Q. And the indication of the
 8 label would be on-label use of those
 9 products.
 10 So that would be if a
 11 physician prescribed -- let's take
 12 Fentora, for example. If a physician
 13 prescribed Fentora for breakthrough pain
 14 in a patient that he or she had who had
 15 cancer and was opioid tolerant, that
 16 would be on-label prescribing, correct?
 17 A. Correct.
 18 Q. Okay. You also understood
 19 that there was the potential for
 20 off-label prescribing by physicians to
 21 prescribe the product for breakthrough
 22 pain in a patient who didn't have cancer,
 23 for example, correct?
 24 A. Correct.

1 promote products off label, correct?
 2 MS. HILLYER: Same
 3 objection. Asked and answered.
 4 And calls for a legal conclusion.
 5 You can answer if you can.
 6 THE WITNESS: Based on the
 7 way you phrased the question, I
 8 would answer yes.
 9 BY MS. RUANE:
 10 Q. And you knew that the reason
 11 it was illegal to promote Fentora, as an
 12 example, off label, was because the FDA
 13 indication was limited to breakthrough
 14 cancer pain in opioid-tolerant patients,
 15 correct?
 16 MS. HILLYER: Objection to
 17 form. And calls for a legal
 18 conclusion.
 19 MS. RUANE: Would you like
 20 me to rephrase it, or are you able
 21 to answer?
 22 THE WITNESS: I think the
 23 answer is -- rephrase it, because
 24 I want to make sure I answer

1 correctly.
 2 BY MS. RUANE:
 3 Q. Sure.
 4 So we know that you
 5 understood off-label marketing, marketing
 6 or promoting a product like Fentora for
 7 something beyond breakthrough cancer pain
 8 in opioid-tolerant patients, was against
 9 the law, right?
 10 MS. HILLYER: Same
 11 objection. Asked and answered.
 12 And calls for a legal conclusion.
 13 BY MS. RUANE:
 14 Q. That's correct?
 15 A. Yes.
 16 Q. And describing pain as, pain
 17 is pain, or breakthrough cancer pain is
 18 the same thing as breakthrough pain is
 19 off-label marketing, isn't it?
 20 MS. HILLYER: Objection to
 21 form.
 22 THE WITNESS: I don't -- I
 23 don't -- I don't think that you're
 24 accurate, no.

1 MS. HILLYER: Objection to
 2 form. It calls for a legal
 3 conclusion.
 4 THE WITNESS: In the context
 5 that you're stating, which I think
 6 is pretty broad, I would agree
 7 with you.
 8 BY MS. RUANE:
 9 Q. And so it's important that
 10 the phrase "pain is pain" be well
 11 defined; because if "pain is pain" is
 12 actually addressing the argument that
 13 breakthrough cancer pain and breakthrough
 14 pain of any other sort are the exact same
 15 thing, that would be off-label marketing,
 16 wouldn't it?
 17 MS. HILLYER: Objection to
 18 form. Calls for legal conclusion.
 19 Argumentative. And vague.
 20 You can answer if you
 21 understand the questions.
 22 THE WITNESS: I'm not
 23 familiar with the "pain is pain"
 24 relative to any of my experience

1 BY MS. RUANE:
 2 Q. You agree that the only
 3 on-label use for both Actiq and Fentora
 4 was breakthrough cancer pain, correct?
 5 MS. HILLYER: Objection to
 6 form.
 7 You can answer.
 8 THE WITNESS: The
 9 indication, you're correct.
 10 BY MS. RUANE:
 11 Q. And so any promotion or
 12 marketing which attempted to expand the
 13 idea of pain from breakthrough cancer
 14 pain to breakthrough pain would be
 15 off-label marketing, wouldn't it?
 16 MS. HILLYER: Objection to
 17 form. That's confusing.
 18 THE WITNESS: I mean, that's
 19 too vague.
 20 BY MS. RUANE:
 21 Q. Do you believe that
 22 marketing a product like Fentora for
 23 breakthrough pain, without any reference
 24 to cancer, is off-label marketing?

1 within the organization. So I
 2 can't answer it.
 3 BY MS. RUANE:
 4 Q. Okay. Thank you. And
 5 that's a fair point.
 6 So in your memory, you have
 7 never used the phrase "pain is pain" --
 8 A. No.
 9 Sorry.
 10 Q. And let me ask it again,
 11 just to make sure we're not stepping on
 12 each other.
 13 In your memory, you have not
 14 used the phrase "pain is pain" in the
 15 promotion or marketing of an opioid
 16 product?
 17 A. Not to my recollection.
 18 Q. And using the phrase "pain
 19 is pain" in marketing an opioid product
 20 like Fentora would be off-label
 21 marketing, wouldn't it?
 22 MS. HILLYER: Objection.
 23 Very vague. And calls for a legal
 24 conclusion.

<p style="text-align: right;">Page 73</p> <p>1 Any opioid product?</p> <p>2 MS. RUANE: I said Fentora.</p> <p>3 MS. HILLYER: You said like</p> <p>4 Fentora.</p> <p>5 MS. RUANE: Let me ask it</p> <p>6 again.</p> <p>7 BY MS. RUANE:</p> <p>8 Q. Would you have allowed, in</p> <p>9 your role as managed care -- as -- excuse</p> <p>10 me.</p> <p>11 Would you have allowed, in</p> <p>12 your role as director of healthcare</p> <p>13 systems marketing, to -- an employee of</p> <p>14 yours to market to a managed care entity</p> <p>15 the use of Fentora with the description,</p> <p>16 pain is pain?</p> <p>17 MS. HILLYER: Objection to</p> <p>18 form.</p> <p>19 THE WITNESS: There was no</p> <p>20 direction from me to any of my</p> <p>21 team to make that statement, ever.</p> <p>22 BY MS. RUANE:</p> <p>23 Q. And you wouldn't direct</p> <p>24 anyone to make that statement because</p>	<p style="text-align: right;">Page 74</p> <p>1 that would be off-label marketing,</p> <p>2 wouldn't it?</p> <p>3 A. It's vague.</p> <p>4 MS. HILLYER: Objection to</p> <p>5 form.</p> <p>6 THE WITNESS: In context, I</p> <p>7 don't -- I don't think I can agree</p> <p>8 with you.</p> <p>9 BY MS. RUANE:</p> <p>10 Q. You don't think -- I want to</p> <p>11 make sure I understand. If you're not</p> <p>12 agreeing with me, I want to make sure I</p> <p>13 understand why.</p> <p>14 In your role as director,</p> <p>15 you would not have authorized, and you</p> <p>16 don't believe you would -- you did ever</p> <p>17 authorize, the use of the phrase "pain is</p> <p>18 pain" in promotion or marketing of</p> <p>19 Fentora?</p> <p>20 A. That's correct.</p> <p>21 Q. And the reason -- I mean,</p> <p>22 you obviously have no memory of it.</p> <p>23 But the reason -- am I</p> <p>24 correct that the reason you think you</p>
<p style="text-align: right;">Page 75</p> <p>1 would not have authorized that is because</p> <p>2 that would be marketing the product</p> <p>3 beyond its indication of breakthrough</p> <p>4 cancer pain?</p> <p>5 MS. HILLYER: Objection to</p> <p>6 form.</p> <p>7 THE WITNESS: I could see a</p> <p>8 situation in which you're</p> <p>9 having -- you're just making a</p> <p>10 statement of what I would say is</p> <p>11 context, or maybe opportunities to</p> <p>12 have a conversation, in which</p> <p>13 you're talking about pain</p> <p>14 management.</p> <p>15 But we always stuck to the</p> <p>16 label, as far as what the</p> <p>17 indication is for our product.</p> <p>18 So there's, obviously,</p> <p>19 conversations that people have</p> <p>20 relative to pain management. But</p> <p>21 in terms of actually promoting and</p> <p>22 recommending it, as it relates to</p> <p>23 Fentora, that would not happen.</p> <p>24 BY MS. RUANE:</p>	<p style="text-align: right;">Page 76</p> <p>1 Q. Okay. And if it did happen,</p> <p>2 it would have been off-label marketing,</p> <p>3 correct?</p> <p>4 MS. HILLYER: Objection to</p> <p>5 form.</p> <p>6 THE WITNESS: Again, there's</p> <p>7 various types of pain. You're</p> <p>8 probably aware. There's</p> <p>9 nociceptive pain, neuropathic</p> <p>10 pain.</p> <p>11 So, again, I see this as a</p> <p>12 very strong, broad statement. If</p> <p>13 you want to get specific about all</p> <p>14 the different types of pain, low</p> <p>15 back pain and all that, then we</p> <p>16 can talk about that.</p> <p>17 BY MS. RUANE:</p> <p>18 Q. And there are.</p> <p>19 And, in fact, at some point,</p> <p>20 Teva authored and issued letters of</p> <p>21 medical necessity on different types of</p> <p>22 pain, correct?</p> <p>23 MS. HILLYER: Objection.</p> <p>24 BY MS. RUANE:</p>

<p style="text-align: right;">Page 77</p> <p>1 Q. Including back pain?</p> <p>2 MS. HILLYER: Objection.</p> <p>3 Assumes facts not in evidence.</p> <p>4 BY MS. RUANE:</p> <p>5 Q. We can look at them in a</p> <p>6 little bit. I'm just asking if you</p> <p>7 remember.</p> <p>8 A. I believe so, yes.</p> <p>9 Q. My question for you is a</p> <p>10 little bit different.</p> <p>11 If the description of "pain</p> <p>12 is pain" was being used in reference to</p> <p>13 breakthrough cancer pain, and any other</p> <p>14 breakthrough pain in a patient who</p> <p>15 doesn't have cancer, is the same because</p> <p>16 all pain is pain, that would have been</p> <p>17 off-label marketing, correct?</p> <p>18 MS. HILLYER: Objection to</p> <p>19 form.</p> <p>20 THE WITNESS: Again, I</p> <p>21 feel -- I'm going to give you a</p> <p>22 yes, in the sense of you're</p> <p>23 pushing me to state something that</p> <p>24 I believe is somewhat out of</p>	<p style="text-align: right;">Page 78</p> <p>1 context.</p> <p>2 Because I have not seen</p> <p>3 anything specific to pain is pain.</p> <p>4 BY MS. RUANE:</p> <p>5 Q. But given the information I</p> <p>6 provided you, you would agree with that</p> <p>7 statement?</p> <p>8 A. I'm not an expert on all the</p> <p>9 nuances of off-label promotion.</p> <p>10 But based on the way you</p> <p>11 have asked me, a number of times, I would</p> <p>12 answer, to the best of my knowledge, the</p> <p>13 way that you've asked the question, yes.</p> <p>14 Q. Okay. Let's move on to</p> <p>15 Exhibit-4.</p> <p>16 MS. HILLYER: We've been</p> <p>17 going about an hour. Do you want</p> <p>18 to take a quick break?</p> <p>19 MS. RUANE: That's perfect.</p> <p>20 Let's take a break.</p> <p>21 VIDEO TECHNICIAN: Going off</p> <p>22 record. 10:29 a.m.</p> <p>23 - - -</p> <p>24 (Whereupon, a brief recess</p>
<p style="text-align: right;">Page 79</p> <p>1 was taken.)</p> <p>2 - - -</p> <p>3 VIDEO TECHNICIAN: Back on</p> <p>4 record. 10:42 a.m.</p> <p>5 BY MS. RUANE:</p> <p>6 Q. Back on record after a short</p> <p>7 break.</p> <p>8 You understand you're still</p> <p>9 under oath?</p> <p>10 A. I do.</p> <p>11 Q. Okay. We're going to hand</p> <p>12 you Exhibit-4, Bates range</p> <p>13 TEVA_MDL_A_04838673 to 77.</p> <p>14 - - -</p> <p>15 (Whereupon, Teva-Bearer</p> <p>16 Exhibit-4,</p> <p>17 TEVA_MDL_A_04838673-677, was</p> <p>18 marked for identification.)</p> <p>19 - - -</p> <p>20 BY MS. RUANE:</p> <p>21 Q. This is a document you</p> <p>22 authored as the national account</p> <p>23 manager --</p> <p>24 A. Okay.</p>	<p style="text-align: right;">Page 80</p> <p>1 Q. -- correct?</p> <p>2 MS. HILLYER: Take your time</p> <p>3 to look it through.</p> <p>4 THE WITNESS: Okay. Yes, my</p> <p>5 name is on it, and it looks</p> <p>6 familiar.</p> <p>7 BY MS. RUANE:</p> <p>8 Q. The first page, Page 73,</p> <p>9 you'll see an advocacy bullet point</p> <p>10 there?</p> <p>11 A. Yes.</p> <p>12 Q. That indicates,</p> <p>13 Advocacy-cultivate key physicians in each</p> <p>14 target market to assist in influencing</p> <p>15 key account formulary committees,</p> <p>16 establishing PA criteria and guidelines,</p> <p>17 challenging existing restrictions, et</p> <p>18 cetera.</p> <p>19 And then, Coordinate</p> <p>20 peer-to-peer discussions and share best</p> <p>21 practices.</p> <p>22 Is that correct?</p> <p>23 A. That's what it says, yes.</p> <p>24 Q. Got it.</p>

1 We talked about the goal to
 2 get, I guess at this point it would have
 3 been Actiq, on to the formulary?
 4 MS. HILLYER: Objection to
 5 form.
 6 BY MS. RUANE:
 7 Q. We talked about that, prior?
 8 A. You're implying that it
 9 wasn't on formulary. This is -- these
 10 are global objectives for all brands.
 11 Q. Okay. One of the goals with
 12 Actiq was to make sure that -- or to get
 13 it on to formulary, if it wasn't,
 14 correct?
 15 A. Yes.
 16 Q. And so you influenced --
 17 your goal was to cultivate key physicians
 18 to assist in influencing key account
 19 formulary committees for that purpose,
 20 correct?
 21 A. That's correct.
 22 Q. We've also talked about
 23 prior authorization and you explained how
 24 that works.

1 would be considered a restriction
 2 that is appropriate.
 3 BY MS. RUANE:
 4 Q. What about cancer pain, was
 5 that considered a restriction that was
 6 appropriate for Actiq?
 7 MS. HILLYER: Objection to
 8 form.
 9 THE WITNESS: That is -- let
 10 me state first that for both
 11 Actiq, as it evolved in the
 12 marketplace, prior authorizations
 13 were required. Often they default
 14 to label. Often they can include
 15 beyond label. It depends.
 16 So there's not one answer to
 17 your question.
 18 BY MS. RUANE:
 19 Q. Okay. My question for you,
 20 as the national account manager who
 21 drafted this document --
 22 A. Yes.
 23 Q. -- was, you gave the example
 24 of opioid-tolerant patients as an

1 One of the goals was to
 2 establish prior authorization criteria
 3 and guidelines and to challenge existing
 4 restrictions, correct?
 5 A. This is a broad statement.
 6 We don't know what the
 7 restrictions are. In general. It's a
 8 broad objective.
 9 Q. And that would have been
 10 true as it relates to Actiq, to challenge
 11 whatever existing restrictions there were
 12 regarding prior authorization, correct?
 13 MS. HILLYER: Objection to
 14 form.
 15 THE WITNESS: Again, a broad
 16 statement. There may be
 17 restrictions that are appropriate.
 18 So just to make a blanket
 19 statement about restrictions
 20 doesn't imply that some -- prior
 21 authorizations often include very
 22 appropriate restrictions as well,
 23 like, for example, tolerance to
 24 opioid, opioid tolerance. That

1 appropriate indication that wouldn't --
 2 that you wouldn't attempt to establish
 3 prior authorization criteria beyond; is
 4 that correct?
 5 MS. HILLYER: Objection to
 6 form. Mischaracterizes testimony.
 7 THE WITNESS: That's not
 8 what I said.
 9 BY MS. RUANE:
 10 Q. What was your example for
 11 opioid-tolerant patients? What were you
 12 referring to?
 13 A. What I'm referring to is,
 14 for everyone's edification, prior
 15 authorizations often have very specific
 16 requirements, it's called criteria, not
 17 necessarily restrictions, criteria that
 18 the plan determines.
 19 Each plan makes their own
 20 determination, based on the clinical data
 21 and what's available to them from what's
 22 going on in the marketplace.
 23 If they choose to cover it
 24 beyond label, that's their privilege to

<p style="text-align: right;">Page 85</p> <p>1 do so.</p> <p>2 And each plan, if you were</p> <p>3 to look at a prior authorization form,</p> <p>4 might have very specific criteria that</p> <p>5 varies from one plan to another. And</p> <p>6 that is up to the P&T committee and the</p> <p>7 clinical team for that health plan.</p> <p>8 Q. And one of the goals, as a</p> <p>9 national account manager at that time,</p> <p>10 was to assist in establishing that prior</p> <p>11 authorization criteria, correct?</p> <p>12 A. It depends. It's part of</p> <p>13 the -- you have a clinical discussion</p> <p>14 with the team -- with the plan. And they</p> <p>15 write their PA criteria, we do not.</p> <p>16 Q. And at least at that time,</p> <p>17 on Page 74, under, Anthem pharmacy</p> <p>18 services --</p> <p>19 A. Yep.</p> <p>20 Q. -- the fourth bullet point</p> <p>21 down, it looks like, to the extent Actiq</p> <p>22 had updated clinical information, that</p> <p>23 was going to be provided?</p> <p>24 A. That's what it says, yes.</p>	<p style="text-align: right;">Page 86</p> <p>1 Q. Let's turn to Page 77, it's</p> <p>2 the last page.</p> <p>3 You'll see there, there's a</p> <p>4 heading, Manage resources effectively?</p> <p>5 A. Uh-huh.</p> <p>6 Q. The second-to-last bullet</p> <p>7 point indicates, Learn and utilize Actiq</p> <p>8 white paper, when available, to present</p> <p>9 data to plans.</p> <p>10 A. That's what it says.</p> <p>11 Q. Is the Actiq white paper the</p> <p>12 same as the dossier?</p> <p>13 A. No.</p> <p>14 Q. What was the Actiq white</p> <p>15 paper?</p> <p>16 A. I honestly don't remember.</p> <p>17 I remember there was one, but I don't</p> <p>18 recall specifically what it was.</p> <p>19 Q. Do you recall who was</p> <p>20 involved in creating it?</p> <p>21 A. I honestly don't.</p> <p>22 - - -</p> <p>23 (Whereupon, Teva-Bearer</p> <p>24 Exhibit-5,</p>
<p style="text-align: right;">Page 87</p> <p>1 TEVA_MDL_A_04838485-490, was</p> <p>2 marked for identification.)</p> <p>3 - - -</p> <p>4 BY MS. RUANE:</p> <p>5 Q. I'm going to hand you what's</p> <p>6 been marked as Exhibit-5.</p> <p>7 This is a similar document,</p> <p>8 just for 2005, correct?</p> <p>9 MS. HILLYER: Take your time</p> <p>10 to look it over.</p> <p>11 BY MS. RUANE:</p> <p>12 Q. And I'll tell you -- I mean,</p> <p>13 take the time you need. But I'll tell</p> <p>14 you I'm just going to ask you one or two</p> <p>15 questions, and then we'll move on.</p> <p>16 A. Okay.</p> <p>17 Q. On Page 2 of that document,</p> <p>18 86, it's, I guess, the -- it's hard to</p> <p>19 describe, right above Cigna, I guess, the</p> <p>20 last bullet point right above Cigna, one</p> <p>21 of the things included was to broaden the</p> <p>22 Actiq prior authorization criteria?</p> <p>23 A. Yep.</p> <p>24 Q. And below that is an MEP on</p>	<p style="text-align: right;">Page 88</p> <p>1 pain management, correct?</p> <p>2 A. Correct.</p> <p>3 Q. What's an MEP?</p> <p>4 A. Medical education program.</p> <p>5 Q. And so medical education</p> <p>6 programs would be provided to managed</p> <p>7 care entities with the goal of broadening</p> <p>8 the Actiq prior authorization criteria,</p> <p>9 correct?</p> <p>10 A. Not necessarily. Managed</p> <p>11 care organizations don't treat patients,</p> <p>12 so we spend a lot of time with medical</p> <p>13 education programs, particularly in the</p> <p>14 pain area.</p> <p>15 And you give them -- it's</p> <p>16 like a disease state type of presentation</p> <p>17 to educate them, because we can't assume</p> <p>18 that every pharmacy director has working</p> <p>19 knowledge of all the different</p> <p>20 therapeutic areas or all the medications.</p> <p>21 Q. And in this case, the pain</p> <p>22 management education is referenced, below</p> <p>23 the goal, to broaden Actiq prior</p> <p>24 authorization criteria; you would agree?</p>

<p style="text-align: right;">Page 89</p> <p>1 A. That's what it says.</p> <p>2 Q. Okay. And there's also an</p> <p>3 indication that the team is going to work</p> <p>4 with the field to drive appeals and</p> <p>5 letters of medical necessity, correct?</p> <p>6 A. That's what it says.</p> <p>7 Q. That's also under the</p> <p>8 heading of, Broaden Actiq prior</p> <p>9 authorization criteria, correct?</p> <p>10 A. Correct.</p> <p>11 Q. And the field would be</p> <p>12 individuals -- sales representatives</p> <p>13 calling on physicians, correct?</p> <p>14 A. Let me make sure I'm</p> <p>15 answering you correctly.</p> <p>16 Field -- yes.</p> <p>17 Q. And the sales</p> <p>18 representatives calling on the field --</p> <p>19 or within the field would be tasked with,</p> <p>20 rather than having their -- the</p> <p>21 physicians they call on accept a denial,</p> <p>22 to undergo the appeal process and, if</p> <p>23 necessary, submit a letter of medical</p> <p>24 necessity, correct?</p>	<p style="text-align: right;">Page 90</p> <p>1 MS. HILLYER: Objection.</p> <p>2 Calls for speculation. Lack of</p> <p>3 foundation.</p> <p>4 THE WITNESS: Why don't you</p> <p>5 rephrase?</p> <p>6 BY MS. RUANE:</p> <p>7 Q. Sure.</p> <p>8 When it says, Work with the</p> <p>9 field to drive appeals and letters of</p> <p>10 medical necessity, that is to drive an</p> <p>11 increase in the number of appeals and</p> <p>12 letters of medical necessity, correct?</p> <p>13 MS. HILLYER: Objection.</p> <p>14 Calls for speculation.</p> <p>15 THE WITNESS: This was a</p> <p>16 time when prior authorizations,</p> <p>17 letters of medical necessity, was</p> <p>18 not as commonplace for many</p> <p>19 offices.</p> <p>20 The idea behind prior</p> <p>21 authorizations and letters of</p> <p>22 medical necessity was to ensure</p> <p>23 that the office staff was familiar</p> <p>24 with the process, to ensure</p>
<p style="text-align: right;">Page 91</p> <p>1 appropriate patients, as deemed</p> <p>2 appropriate by the physician, had</p> <p>3 access to Fentora.</p> <p>4 BY MS. RUANE:</p> <p>5 Q. And so to drive the number</p> <p>6 of appeals and letters of medical</p> <p>7 necessity would have the effect of</p> <p>8 increasing, potentially, the number of</p> <p>9 patients who, although they were first</p> <p>10 denied, upon appeal and submission of a</p> <p>11 letter of medical necessity, were able to</p> <p>12 receive the opioid, correct?</p> <p>13 MS. HILLYER: Objection to</p> <p>14 form.</p> <p>15 THE WITNESS: While I'll</p> <p>16 state that you're -- the prior</p> <p>17 authorization, the reasons for</p> <p>18 denials of prior authorizations</p> <p>19 are many, many; not just based on</p> <p>20 diagnosis and indication. So I</p> <p>21 want to clarify that.</p> <p>22 BY MS. RUANE:</p> <p>23 Q. And I appreciate that.</p> <p>24 The practical effect of a</p>	<p style="text-align: right;">Page 92</p> <p>1 denial is that medication is not going to</p> <p>2 be paid for and the patient won't receive</p> <p>3 the medication, correct?</p> <p>4 A. That's part of it. It could</p> <p>5 be that the information is not complete,</p> <p>6 the requirement for prior therapies is</p> <p>7 not documented.</p> <p>8 So, like I say, there are</p> <p>9 many reasons why prior authorizations are</p> <p>10 denied.</p> <p>11 Q. And my question was a little</p> <p>12 different.</p> <p>13 The practical effect of</p> <p>14 that, if there's a denial, is that</p> <p>15 medication is not going to be paid for,</p> <p>16 the patient is not going to receive that</p> <p>17 medication, correct?</p> <p>18 A. The patient can pay cash,</p> <p>19 but the payer is not going to pay for it.</p> <p>20 Q. If the patient doesn't pay</p> <p>21 cash, excluding an out-of-pocket payment,</p> <p>22 then the practical effect would be the</p> <p>23 patient doesn't receive the medication --</p> <p>24 that medication, correct?</p>

1 A. Correct.
 2 Q. And so Teva, or Cephalon, I
 3 guess at this time --
 4 A. Right.
 5 Q. -- doesn't receive that
 6 profit, correct?
 7 A. The script won't be filled.
 8 Q. And Teva, or Cephalon at
 9 that time, doesn't receive the profit for
 10 that script, correct?
 11 MS. HILLYER: Objection to
 12 form.
 13 But you can answer.
 14 BY MS. RUANE:
 15 Q. That's a true statement,
 16 isn't it?
 17 MS. HILLYER: Same
 18 objection.
 19 THE WITNESS: That sales --
 20 sale would not be recognized by
 21 Teva or Cephalon.
 22 BY MS. RUANE:
 23 Q. The sale wouldn't be
 24 recognized, and Teva or Cephalon wouldn't

1 receive the money, correct?
 2 A. Unless the patient paid
 3 cash.
 4 Q. And so one of the goals, in
 5 order to increase the profits, would be
 6 to utilize appeals and letters of medical
 7 necessity in order to drive and increase
 8 the number of patients who receive, at
 9 this time, Actiq, correct?
 10 MS. HILLYER: Objection to
 11 form.
 12 THE WITNESS: The premise
 13 for driving appeals and/or
 14 educating the staff is to ensure
 15 the patient had access. The
 16 result of that, of course, would
 17 be Cephalon would receive a sale.
 18 BY MS. RUANE:
 19 Q. Okay.
 20 A. Appropriate patients having
 21 access.
 22 Q. And that process has
 23 continued, as far as -- strike that.
 24 Let me ask a better

1 question. The process of utilizing
 2 appeals and letters of medical necessity
 3 in order to assist in patients receiving
 4 the medication continued with Fentora,
 5 correct?
 6 MS. HILLYER: Objection to
 7 the form.
 8 THE WITNESS: I'm trying to
 9 remember. There were various
 10 discussions around what letters of
 11 medical necessity would be
 12 available.
 13 I believe we did have them
 14 for Fentora, as I recall.
 15 BY MS. RUANE:
 16 Q. Okay.
 17 A. And mind you, letters of
 18 medical necessity are managed through our
 19 medical department, not me.
 20 Q. On Page 87, toward the very
 21 bottom, it's actually the second bullet
 22 point above Eckerd Health Services, it
 23 indicates, Continue to develop
 24 relationships with local Actiq advocates.

1 A. Yep.
 2 Q. So the -- are "local Actiq
 3 advocates" physicians who prescribe
 4 Actiq?
 5 A. Yes.
 6 Q. And one of the things you
 7 were tasked with, in your role, was to
 8 continue to develop those relationships,
 9 correct?
 10 A. Typically, working with
 11 sales teams not individually.
 12 Q. So what you would do would
 13 be to coordinate with the sales teams in
 14 order to ensure that they were developing
 15 positive relationships with the
 16 physicians who you all considered to be
 17 Actiq advocates?
 18 A. That's true with every
 19 product.
 20 Q. That's also true with the
 21 Fentora product, correct?
 22 A. It's true with any -- that's
 23 a standard practice in the industry.
 24 And I'll clarify. When

1 products may or may not be added to
 2 formulary, many times pain specialists
 3 are not a part of their P&T, so they rely
 4 on those physicians we're referring to
 5 for input in the decision-making.
 6 Rarely have I ever seen or
 7 heard of a pain specialist sitting on a
 8 P&T committee that ultimately makes the
 9 decision as to whether it's on formulary
 10 and what the criteria covered -- what the
 11 coverage criteria is.
 12 Q. So breaking that up, the P&T
 13 committee is the committee that decides
 14 whether a drug ends up on formulary,
 15 correct?
 16 A. They make a recommendation.
 17 And then there's a financial piece to it
 18 that the contracting side or the trade
 19 side of the plan makes a determination,
 20 based on the cost of the drug, et cetera.
 21 Q. So the P&T committee makes
 22 the recommendation on whether a drug
 23 should end up on formulary, correct?
 24 A. Yes.

1 Q. And the role that Teva plays
 2 in that is to maintain relationships with
 3 those physicians?
 4 MS. HILLYER: Objection to
 5 form.
 6 THE WITNESS: Teva?
 7 BY MS. RUANE:
 8 Q. And Cephalon.
 9 A. But you're -- it's a
 10 broad -- I mean, who? Who in Teva?
 11 Q. Well, my question is,
 12 because on your managed care and
 13 reimbursement objectives, one of your
 14 bullet points is to continue to develop
 15 relationships with local Actiq advocates.
 16 A. Yes.
 17 Q. So my question is posed to
 18 you because that's in a document that has
 19 your name on it.
 20 A. Okay.
 21 Q. Would you agree --
 22 A. That was an objective.
 23 Q. -- that was an objective?
 24 A. Sorry.

1 Q. And Cephalon, and then Teva,
 2 recognized that utilizing physician
 3 advocates who advocate for their products
 4 was a helpful step in obtaining formulary
 5 status for their products?
 6 MS. HILLYER: Objection to
 7 form.
 8 THE WITNESS: It's a broad
 9 statement, because there's no
 10 suggestion of -- I mean, if a plan
 11 decides not to cover it at all,
 12 you need an advocate to say, we
 13 need this product.
 14 It has nothing to do with
 15 what the indication is, or what
 16 have you, at that point.
 17 BY MS. RUANE:
 18 Q. I'm sorry?
 19 A. So what I'm trying to say
 20 is, yes, physicians are often tasked,
 21 with their expertise in certain specialty
 22 areas, for making -- giving opinions to
 23 the P&T committee, clinical -- based on
 24 their practice.

1 Q. And that was also an
 2 objective with the Fentora product,
 3 correct?
 4 MS. HILLYER: Asked and
 5 answered.
 6 You can answer again.
 7 THE WITNESS: Again, going
 8 back to the timeline, the majority
 9 of my involvement with Fentora was
 10 not customer-facing.
 11 BY MS. RUANE:
 12 Q. But in your role at Teva,
 13 you were aware of the fact that the goal
 14 of maintaining relationships with patient
 15 advocates in order to make sure there's
 16 somebody to advocate for Fentora on the
 17 formulary maintained a goal of the
 18 organization, correct?
 19 A. You stated patient --
 20 MS. HILLYER: Objection to
 21 form.
 22 THE WITNESS: You stated
 23 patient advocate. You said
 24 patient advocate.

1 BY MS. RUANE:

2 Q. Let me ask the question
3 again.

4 In your role, though your
5 position changed, but you're aware of the
6 fact that it maintained -- that Teva
7 maintained, as a goal, to develop
8 relationships with advocates for Fentora
9 in order to, hopefully, provide somebody
10 to advocate for the use of Fentora on the
11 formulary?

12 A. So as I stated in previous
13 comments relative to the landscape of
14 managed care, back when Actiq was
15 promoted, many times the role of an
16 account manager was just as you stated in
17 the objectives.

18 That evolved into a very
19 relatively ineffective way to have
20 physician advocates. It's really up to
21 the sales representatives in the
22 marketplace to promote the product
23 appropriately to all physicians, whether
24 they are KOLs or not.

1 So the practice of -- of an
2 account manager personally getting to
3 know a KOL was really not the norm in the
4 Fentora time frame.

5 Q. So that was a shift from a
6 practice that occurred with Actiq?

7 A. Yes, I would say it is.

8 Q. Okay.

9 A. And -- yes.

10 Q. All right.

11 - - -

12 (Whereupon, Teva-Bearer
13 Exhibit-6,
14 TEVA_MDL_A_04484212-214, was
15 marked for identification.)

16 - - -

17 MS. RUANE: I'm going to
18 hand you what's been marked as
19 Exhibit-6. For the record, this
20 is TEVA_MDL_A_04484212 through 14.

21 BY MS. RUANE:

22 Q. If you look down to the
23 second message there, the e-mail from
24 Terry Terifay.

1 Are you cc'd on this e-mail?

2 A. The second one, yes.

3 Q. And this is referencing that
4 Actiq white paper --

5 A. Okay.

6 Q. -- that we talked about
7 earlier?

8 MS. HILLYER: Take your time
9 to look through it if you need to.

10 THE WITNESS: Okay. Yes.

11 BY MS. RUANE:

12 Q. Terry's e-mail, on which you
13 were cc'd, indicates that, in the first
14 line, This document is going to be a
15 great initiative as we roll out our 2005
16 tactics to address issues around
17 reimbursement for Actiq.

18 Did I read that correctly?

19 A. Wait a minute. This one
20 here?

21 Sorry. I was looking --
22 yes, that's what it says. Sorry.

23 Q. So this Actiq white paper
24 was going to be used with managed care

1 entities, correct?

2 A. Yes.

3 Q. And the Actiq white paper
4 was circulated to a certain set of
5 Cephalon employees, some of whom provided
6 feedback, correct?

7 A. I don't, truthfully, recall
8 this. Now that I'm reading it, it's
9 familiar.

10 Q. Okay. And you were included
11 on the e-mail chain with the feedback,
12 correct?

13 A. That was routine, to be
14 cc'd.

15 Q. I'm sorry, what did you say?

16 A. It was -- it was routine
17 for -- you notice I was cc'd by Terry
18 because I was more of the marketing.

19 So he would automatically
20 copy me on things.

21 Q. And in the message below, on
22 which you're cc'd, Bill Cunningham --
23 it's the last sentence on Page 212.

24 A. Yep.

1 Q. We'll talk about the
2 feedback itself in a minute.
3 But Bill indicates,
4 Essentially, the reason behind the need
5 to have the commentary section worded in
6 such a way is to ensure that managed care
7 clearly understands the nature of what is
8 being discussed and does not attempt to
9 misconstrue or misinterpret the
10 information.
11 Do you see that?
12 A. I see that.
13 Q. He goes on and talks about
14 the fact that he doesn't want managed
15 care to attempt to turn the intent of the
16 information around and possibly use it to
17 their own advantage.
18 Do you see that?
19 A. I see that.
20 Q. Do you have an understanding
21 of what he meant by that?
22 A. I do not.
23 MS. HILLYER: Objection.
24 Calls for speculation.

1 it that way.
2 Was he in the managed care
3 group?
4 A. Yes. National account
5 manager.
6 Q. For managed care?
7 A. Yes.
8 Q. He, it looks like, offices
9 out of California?
10 A. Correct.
11 Q. To your knowledge -- well,
12 strike that, let me ask this.
13 Joe had reviewed the Actiq
14 white paper. And under Number 2, so I'm
15 on Page 213, in bold, he gives his
16 suggestions. And he is talking about
17 Module 1.
18 It looks like it said,
19 Breakthrough pain, defined as a transient
20 flare in pain of moderate-to-severe
21 intensity occurring in conjunction with
22 persistent pain, is a prevalent form of
23 pain in patients with cancer or other
24 terminal diseases.

1 BY MS. RUANE:
2 Q. You do not?
3 A. No, I don't know.
4 Q. Okay. Feedback was
5 provided, below that, by Joseph -- I may
6 be mispronouncing it -- Duarte.
7 A. Correct.
8 Q. Do you know Joseph Duarte?
9 A. Yes.
10 Q. Does he have any medical or
11 pharmaceutical training, to your
12 knowledge?
13 A. I don't know.
14 Q. One of the things -- do you
15 know what Joseph's role was with the
16 company?
17 Actually, I say that. Look
18 on Page 214, he's listed as a national
19 account manager?
20 A. Yes. He was a national
21 account manager.
22 Q. And do you know what bucket,
23 I mean, what -- do you know, was he in
24 managed care? Strike that. Let me ask

1 Do you see that?
2 A. I see. Yes. I'm sorry,
3 yes, I do.
4 Q. Do you see the suggestion --
5 he gave a couple different suggestions.
6 One was just to omit the whole thing and
7 end that sentence with, you know,
8 Persistent pain is a prevalent form of
9 pain in patients.
10 Do you see that?
11 MS. HILLYER: Objection. I
12 just want to be clear that it
13 looks like other people may have
14 commented. And because this isn't
15 in color, it's not clear whose
16 comments are whose.
17 MS. RUANE: That's fair.
18 MS. HILLYER: But go ahead.
19 BY MS. RUANE:
20 Q. So within the -- the only
21 reason I ask it that way is because at
22 that point it looks like it's an e-mail
23 just with Bill and Joe.
24 But there may have been

<p style="text-align: right;">Page 109</p> <p>1 others.</p> <p>2 MS. HILLYER: Terry had</p> <p>3 comments, it looks like, perhaps.</p> <p>4 BY MS. RUANE:</p> <p>5 Q. On that July 12th, 2004</p> <p>6 e-mail, he gives three suggestions,</p> <p>7 correct?</p> <p>8 MS. HILLYER: Same -- same</p> <p>9 objection.</p> <p>10 Go ahead.</p> <p>11 BY MS. RUANE:</p> <p>12 Q. Do you see that he gives</p> <p>13 three suggestions there?</p> <p>14 A. I see there are three</p> <p>15 suggestions there.</p> <p>16 I also notice that the font</p> <p>17 is different on C, so I don't know, based</p> <p>18 on what I'm reading here, if, in fact,</p> <p>19 that is actually what -- his comment. I</p> <p>20 don't know.</p> <p>21 Q. Got it.</p> <p>22 Whoever's suggestions they</p> <p>23 are, every -- all three suggestions do</p> <p>24 not limit that definition of breakthrough</p>	<p style="text-align: right;">Page 110</p> <p>1 pain to patients with cancer; is that</p> <p>2 correct?</p> <p>3 A. That's correct.</p> <p>4 Q. If you'll flip the page to</p> <p>5 Page 214, Number 6 there on Module 2,</p> <p>6 there's a question about whether they can</p> <p>7 include the Turk editorial titled,</p> <p>8 Remember the Distinction Between</p> <p>9 Malignant and Benign Pain? Well, forget</p> <p>10 it.</p> <p>11 Do you see that?</p> <p>12 A. Yes, I see it.</p> <p>13 Q. So those were requests made</p> <p>14 by somebody within the Cephalon company,</p> <p>15 as far as edits to the Actiq white paper,</p> <p>16 correct?</p> <p>17 MS. HILLYER: Objection to</p> <p>18 the form.</p> <p>19 You can answer.</p> <p>20 THE WITNESS: What I don't</p> <p>21 remember is if this was more or</p> <p>22 less a disease state type of</p> <p>23 document. I don't remember.</p> <p>24 If it was, then it would</p>
<p style="text-align: right;">Page 111</p> <p>1 make sense to have a distinction,</p> <p>2 you know, between -- there's</p> <p>3 malignant and nonmalignant pain,</p> <p>4 more of an education. That's what</p> <p>5 I don't remember.</p> <p>6 So just looking at this, I</p> <p>7 can't answer your question</p> <p>8 specifically.</p> <p>9 BY MS. RUANE:</p> <p>10 Q. We know it's titled, The</p> <p>11 Actiq White Paper --</p> <p>12 A. Yes.</p> <p>13 Q. -- right?</p> <p>14 Is that correct?</p> <p>15 A. Yes.</p> <p>16 Q. And so the Actiq white</p> <p>17 paper --</p> <p>18 A. Okay.</p> <p>19 Q. -- would reference the drug</p> <p>20 Actiq rather than a more general disease</p> <p>21 state.</p> <p>22 Do you agree?</p> <p>23 A. I think if -- without seeing</p> <p>24 the deck itself in the context of the</p>	<p style="text-align: right;">Page 112</p> <p>1 flow, oftentimes we would have</p> <p>2 promotional decks or decks that would</p> <p>3 give disease state awareness up front,</p> <p>4 that's very common, and then go into the</p> <p>5 product. I have examples currently that</p> <p>6 I use.</p> <p>7 The slides themselves -- and</p> <p>8 I don't remember, but I'm just educating</p> <p>9 you, the slides themselves, anything that</p> <p>10 is nonbranded would have a different</p> <p>11 template, and then transition into a</p> <p>12 branded template when you start speaking</p> <p>13 about the product.</p> <p>14 Q. And --</p> <p>15 A. So --</p> <p>16 Q. And you don't remember, one</p> <p>17 way or another, with this Actiq white</p> <p>18 paper?</p> <p>19 A. I really don't, sorry.</p> <p>20 Q. Based on the names included</p> <p>21 on this e-mail, if you just look at Page</p> <p>22 2, I think all the names are included in</p> <p>23 the July 20th, 2004 portion of the</p> <p>24 e-mail, on Page 212, where Terry sends it</p>

<p style="text-align: right;">Page 113</p> <p>1 out and cc's you, can you tell me, based</p> <p>2 on your knowledge, whether anyone on that</p> <p>3 e-mail has any medical training as a</p> <p>4 physician or a pharmacist?</p> <p>5 A. I know for a fact Susan</p> <p>6 Larijani does, she's in medical services.</p> <p>7 I don't know the background of Joe, other</p> <p>8 than my relationship with him at</p> <p>9 Cephalon.</p> <p>10 Andy Pyfer is -- I don't</p> <p>11 believe has medical. Nor Bill.</p> <p>12 Q. Do you happen to know what</p> <p>13 Susan's training is?</p> <p>14 A. No.</p> <p>15 MS. RUANE: I'm going to</p> <p>16 hand you Exhibit-7, which, for the</p> <p>17 record, is TEVA_MDL_A_04478352</p> <p>18 through 356.</p> <p>19 - - -</p> <p>20 (Whereupon, Teva-Bearer</p> <p>21 Exhibit-7,</p> <p>22 TEVA_MDL_A_04478352-356, was</p> <p>23 marked for identification.)</p> <p>24 - - -</p>	<p style="text-align: right;">Page 114</p> <p>1 MS. HILLYER: This is 7, you</p> <p>2 said?</p> <p>3 MS. RUANE: Yes.</p> <p>4 BY MS. RUANE:</p> <p>5 Q. This is a follow-up e-mail.</p> <p>6 Susan indicates, on the</p> <p>7 first page in the first sentence, Q and I</p> <p>8 have reviewed your collective comments</p> <p>9 and I have incorporated most of them in</p> <p>10 to the final document.</p> <p>11 Do you see that?</p> <p>12 A. I do.</p> <p>13 Q. Do you have any idea who Q</p> <p>14 is?</p> <p>15 A. Medical director.</p> <p>16 Q. And that would have been the</p> <p>17 medical director for --</p> <p>18 A. Pain.</p> <p>19 Q. Pain.</p> <p>20 What's Q's full name?</p> <p>21 A. It's in the cc at the top.</p> <p>22 They called him Q, but it's K-I-U-M --</p> <p>23 Q. Got it.</p> <p>24 So for the record, that's</p>
<p style="text-align: right;">Page 115</p> <p>1 K-I-U-M-A-R-S; last name, V-A-D-I-E-I?</p> <p>2 A. Correct.</p> <p>3 Q. I'm not going to try to</p> <p>4 pronounce that.</p> <p>5 A. That's why he was called Q.</p> <p>6 Q. In any event, in this</p> <p>7 document Susan includes, for example, on</p> <p>8 Number 2, Subparagraph D, what the</p> <p>9 revision is going to be.</p> <p>10 Do you see that?</p> <p>11 A. I do.</p> <p>12 Q. And ultimately, after</p> <p>13 reviewing the comments, the revision to</p> <p>14 the Actiq white paper referenced,</p> <p>15 Breakthrough pain, defined as a transient</p> <p>16 flare in pain of moderate-to-severe</p> <p>17 intensity occurring in conjunction with</p> <p>18 persistent pain, is a prevalent form of</p> <p>19 pain in patients with malignant and</p> <p>20 nonmalignant diseases.</p> <p>21 Do you see that?</p> <p>22 A. I do.</p> <p>23 Q. You would agree that's</p> <p>24 beyond the scope of breakthrough pain in</p>	<p style="text-align: right;">Page 116</p> <p>1 cancer patients?</p> <p>2 MS. HILLYER: Objection to</p> <p>3 form.</p> <p>4 THE WITNESS: Again, I would</p> <p>5 love to see the final deck,</p> <p>6 because these are only</p> <p>7 recommendations.</p> <p>8 BY MS. RUANE:</p> <p>9 Q. We'll get there.</p> <p>10 A. Good. Because I don't --</p> <p>11 I'm answering you based on what I'm</p> <p>12 seeing here.</p> <p>13 I'm assuming the highlight</p> <p>14 is included in the revision, so she added</p> <p>15 it back in. Because it seems like the</p> <p>16 last one was a deletion if it was</p> <p>17 highlighted, or no?</p> <p>18 Q. Yes. That's correct. There</p> <p>19 were several options.</p> <p>20 The one it appears they</p> <p>21 landed on referenced a prevalent form of</p> <p>22 pain in patients with malignant and</p> <p>23 nonmalignant diseases, correct?</p> <p>24 A. That would be appropriate in</p>

1 the disease state slide, for example.
 2 Q. And you would agree that
 3 that revision references disease states
 4 beyond the scope of breakthrough cancer
 5 pain, correct?
 6 A. That's what it states.
 7 Q. Okay. So my statement is
 8 correct?
 9 A. Yes.
 10 Q. Under Module 2, it's
 11 actually just Number 3 there, the
 12 revision that they landed on, it
 13 states -- and I apologize, it's a little
 14 dark -- The use of opioids for the
 15 management of cancer pain is well
 16 accepted and the use of opioids for the
 17 management of nonmalignant pain is
 18 gaining wider acceptance among pain care
 19 specialists.
 20 Do you see that?
 21 A. Yes.
 22 Q. And then it goes on, Several
 23 professional societies -- but it's not a
 24 full sentence, right, at least in this

1 form?
 2 A. Correct.
 3 Q. So this document references
 4 the use of opioids for the management of
 5 nonmalignant pain, correct?
 6 A. Yep. Yes.
 7 Q. So that is not just a
 8 disease state presentation, correct?
 9 MS. HILLYER: Objection to
 10 form.
 11 THE WITNESS: I don't know.
 12 BY MS. RUANE:
 13 Q. It is referencing, you would
 14 agree, the use of opioids, correct?
 15 A. Yes.
 16 Q. And it's referencing the use
 17 of opioids for management of nonmalignant
 18 pain, correct?
 19 A. Yes.
 20 Q. And you would agree that
 21 that's referencing the use of opioids for
 22 something beyond breakthrough cancer
 23 pain, correct?
 24 A. Opioids in general, yes.

1 Q. In an Actiq white paper,
 2 right?
 3 A. That's what I'd like -- yes.
 4 Yes.
 5 It's not uncommon to include
 6 standards of care, et cetera, in what we
 7 would consider -- I'm assuming this is
 8 promotion, but it's not uncommon to do
 9 that.
 10 - - -
 11 (Whereupon, Teva-Bearer
 12 Exhibit-8,
 13 TEVA_MDL_A_10070409-410, was
 14 marked for identification.)
 15 - - -
 16 MS. RUANE: I'm going to
 17 hand you what's been marked as
 18 Exhibit-8. This is
 19 TEVA_MDL_A_10070409 to 410.
 20 BY MS. RUANE:
 21 Q. The second paragraph -- this
 22 one I'll be brief on.
 23 But the second entry, I
 24 guess, from Joe Duarte again, he's

1 requesting the addition of Dr. Tennant's
 2 study to the Actiq white paper. And that
 3 study is entitled, The Use of Oral
 4 Transmucosal Fentanyl Citrate for
 5 Breakthrough Pain in Severe, Nonmalignant
 6 Chronic Pain.
 7 Do you see that?
 8 A. I do.
 9 Q. And so is that consistent
 10 with your memory that the Actiq white
 11 papers would provide medical studies?
 12 A. So I remember -- I stated
 13 earlier, I don't recall a lot of detail
 14 about the white paper.
 15 After reading this, when I
 16 see professional services, that would
 17 come from our medical side, which is
 18 where Susan Larijani resided. Therefore,
 19 this is not a promotional piece.
 20 Q. Am I understanding you
 21 correctly that what you're saying is the
 22 Actiq white paper is not a promotional
 23 piece?
 24 A. Right. Based on my

<p style="text-align: right;">Page 121</p> <p>1 recollection now, after referring to</p> <p>2 professional services. And, typically,</p> <p>3 anything coming from professional</p> <p>4 services would be upon request,</p> <p>5 unsolicited request from a physician.</p> <p>6 Q. So if it's not --</p> <p>7 A. I'm sorry. Not a physician,</p> <p>8 a plan. Sorry.</p> <p>9 Q. Got it.</p> <p>10 So if it's not a promotional</p> <p>11 piece -- the significance to you of the</p> <p>12 fact that it's -- the Actiq white paper</p> <p>13 is not a promotional piece is that it</p> <p>14 means it's not used by you or others when</p> <p>15 you're calling on --</p> <p>16 A. Correct.</p> <p>17 Q. -- managed care entities?</p> <p>18 MS. HILLYER: Make sure she</p> <p>19 finishes.</p> <p>20 BY MS. RUANE:</p> <p>21 Q. I'll do it again, just to be</p> <p>22 sure we're tracking.</p> <p>23 The significance to you of</p> <p>24 the fact that, in your mind, the Actiq</p>	<p style="text-align: right;">Page 122</p> <p>1 white paper was not a promotional piece</p> <p>2 is that it was not used by you or others</p> <p>3 when you're calling upon managed care</p> <p>4 entities?</p> <p>5 A. Correct.</p> <p>6 Q. Okay. Great.</p> <p>7 - - -</p> <p>8 (Whereupon, Teva-Bearer</p> <p>9 Exhibit-9,</p> <p>10 TEVA_MDL_A_04426360-362, was</p> <p>11 marked for identification.)</p> <p>12 - - -</p> <p>13 MS. RUANE: I'm going to</p> <p>14 hand you what's been marked as</p> <p>15 Exhibit-9. This is, for the</p> <p>16 record, TEVA_MDL_A_04426360</p> <p>17 through 362.</p> <p>18 BY MS. RUANE:</p> <p>19 Q. This is an e-mail chain</p> <p>20 between you and Bill Cunningham, correct?</p> <p>21 A. Yeah.</p> <p>22 Q. Who is Bill Cunningham?</p> <p>23 A. My manager.</p> <p>24 Q. And what was his title?</p>
<p style="text-align: right;">Page 123</p> <p>1 A. Probably director of market</p> <p>2 access. We had various titles.</p> <p>3 Q. It looks like -- did you and</p> <p>4 Bill office in the same place?</p> <p>5 A. Bill was located in</p> <p>6 California.</p> <p>7 Q. It looks like you were</p> <p>8 e-mailing Bill to discuss a managed care</p> <p>9 Actiq presentation, correct?</p> <p>10 A. Yes.</p> <p>11 Q. And so that would be a</p> <p>12 promotional piece, correct?</p> <p>13 A. If I'm presenting it, yes.</p> <p>14 Q. You write, in the first line</p> <p>15 of your e-mail on Page 361 --</p> <p>16 A. Yes.</p> <p>17 Q. -- Bill, I wanted to follow</p> <p>18 up with you about the managed care Actiq</p> <p>19 presentation. I think there's a lot of</p> <p>20 great information in these slides and I'm</p> <p>21 sure we can consolidate them to address a</p> <p>22 managed care audience.</p> <p>23 Do you see that?</p> <p>24 A. I do.</p>	<p style="text-align: right;">Page 124</p> <p>1 Q. So that would indicate that</p> <p>2 this is a promotional piece that you or</p> <p>3 your team are going to use to present to</p> <p>4 a managed care audience, correct?</p> <p>5 A. Yep.</p> <p>6 Q. And your thoughts on that,</p> <p>7 you define below.</p> <p>8 There are four topics that</p> <p>9 the slides could be broken into, which</p> <p>10 you include there as defining pain,</p> <p>11 economic impact of pain, pain management</p> <p>12 and Actiq, correct?</p> <p>13 A. Yep.</p> <p>14 Q. And you indicate, The story</p> <p>15 should be built around the objective of</p> <p>16 explaining why providers want to or</p> <p>17 should have access to Actiq.</p> <p>18 Do you see that?</p> <p>19 A. Yep.</p> <p>20 Q. And this is an e-mail that</p> <p>21 you drafted, correct?</p> <p>22 A. Yep.</p> <p>23 Q. And so your plan was to</p> <p>24 provide a slide set promoting the use of</p>

<p style="text-align: right;">Page 125</p> <p>1 Actiq by providers, correct?</p> <p>2 That's a bad question. Let</p> <p>3 me ask it differently.</p> <p>4 You were speaking to managed</p> <p>5 care entities who are evaluating the</p> <p>6 prescriptions for Actiq that prescribers</p> <p>7 out in the field are prescribing,</p> <p>8 correct, to determine whether they will</p> <p>9 be authorized and reimbursed?</p> <p>10 A. Under prior authorization,</p> <p>11 is that -- we talked before about</p> <p>12 formulary access versus prior</p> <p>13 authorization.</p> <p>14 So what is your question?</p> <p>15 Q. Let me ask first, you're</p> <p>16 presenting, at this time, to managed care</p> <p>17 entities in order to educate them about</p> <p>18 Actiq and why providers, healthcare</p> <p>19 providers, either want to or should have</p> <p>20 access to Actiq, correct?</p> <p>21 A. For their patients, correct.</p> <p>22 Q. For their patients.</p> <p>23 And so there may be a couple</p> <p>24 of things that happen as a result of</p>	<p style="text-align: right;">Page 126</p> <p>1 that, if things go your way.</p> <p>2 One of them would be that</p> <p>3 the managed care entity expands the</p> <p>4 criteria that they would use in order to</p> <p>5 authorize use of Actiq?</p> <p>6 MS. HILLYER: Objection to</p> <p>7 form.</p> <p>8 THE WITNESS: You're</p> <p>9 implying that the Actiq coverage</p> <p>10 was not broad. You're making a</p> <p>11 broad statement. Each plan had</p> <p>12 different coverage criteria.</p> <p>13 BY MS. RUANE:</p> <p>14 Q. Were there plans who had</p> <p>15 coverage criteria just for breakthrough</p> <p>16 cancer pain?</p> <p>17 A. Yes.</p> <p>18 Q. And one of things that you</p> <p>19 were doing, when you were promoting Actiq</p> <p>20 to the managed care entities,</p> <p>21 particularly those whose indication was</p> <p>22 for breakthrough cancer pain, was an</p> <p>23 attempt to educate them to expand beyond</p> <p>24 breakthrough cancer pain, correct?</p>
<p style="text-align: right;">Page 127</p> <p>1 MS. HILLYER: Objection to</p> <p>2 form.</p> <p>3 THE WITNESS: It was to</p> <p>4 educate them on pain and -- it</p> <p>5 was, basically, again, talking</p> <p>6 about pain management.</p> <p>7 BY MS. RUANE:</p> <p>8 Q. Okay. And you were</p> <p>9 educating them on pain well beyond</p> <p>10 breakthrough cancer pain, correct?</p> <p>11 A. General pain information,</p> <p>12 pain management.</p> <p>13 Q. And so the answer to my</p> <p>14 question would be, yes, you were</p> <p>15 educating them on pain beyond</p> <p>16 breakthrough cancer pain, correct?</p> <p>17 A. Correct.</p> <p>18 Q. In this slide set in</p> <p>19 particular that you're proposing, you</p> <p>20 start with the overall economic impact of</p> <p>21 pain --</p> <p>22 A. Yep.</p> <p>23 Q. -- setting the stage.</p> <p>24 And then you move to, What</p>	<p style="text-align: right;">Page 128</p> <p>1 does pain look like, correct?</p> <p>2 A. Yep.</p> <p>3 Q. And you paint the picture,</p> <p>4 pain is pain, correct?</p> <p>5 A. Yes, I do.</p> <p>6 Q. And so you were using the</p> <p>7 phrase "pain is pain," while promoting</p> <p>8 Actiq to managed care entities, correct?</p> <p>9 MS. HILLYER: Objection to</p> <p>10 form. Mischaracterizes the</p> <p>11 document.</p> <p>12 THE WITNESS: That is not</p> <p>13 what that says.</p> <p>14 BY MS. RUANE:</p> <p>15 Q. Your proposal for the slides</p> <p>16 to be used in the promotion of Actiq to</p> <p>17 managed care entities included the phrase</p> <p>18 "pain is pain," correct?</p> <p>19 MS. HILLYER: Objection to</p> <p>20 form. Same objection.</p> <p>21 THE WITNESS: This is a</p> <p>22 recommendation on building a slide</p> <p>23 set. There's nothing in this</p> <p>24 document that said anyone would</p>

1 say "pain is pain."
 2 BY MS. RUANE:
 3 Q. But you're -- in referencing
 4 what your goal was for what the slide set
 5 would convey to managed care entities,
 6 you define it as painting the
 7 picture-pain is pain, correct?
 8 A. Based on this document,
 9 that's what it says, yes.
 10 Q. And you include in there
 11 various types of pain, acute, chronic and
 12 breakthrough, correct?
 13 A. Yes.
 14 Q. And that is not limited to
 15 breakthrough cancer pain, is it?
 16 A. No.
 17 Q. You also reference there
 18 BTP.
 19 That references breakthrough
 20 pain, right?
 21 A. Yes.
 22 Q. And BTCP references
 23 breakthrough cancer pain, correct?
 24 A. Yes.

1 breakthrough pain. And it didn't
 2 suggest that it wasn't -- if it
 3 was referencing the product, it
 4 didn't suggest that it wasn't
 5 relevant to the indication.
 6 BY MS. RUANE:
 7 Q. Here --
 8 A. Here.
 9 Q. -- you make the point of
 10 distinguishing between BTP, which you use
 11 to define breakthrough pain, and BTCP,
 12 which you use to define breakthrough
 13 cancer pain, correct?
 14 A. Yes, that's what I stated.
 15 Q. I'm sorry. Do you need to
 16 take a break?
 17 A. No, I was a little worried
 18 about this getting caught. Sorry.
 19 Q. You indicate, Show studies
 20 for each - conclusion, pain is pain, not
 21 treating underlying condition.
 22 Correct?
 23 A. Yep, that's what it says.
 24 Q. The message that you wanted

1 Q. So there is a distinction
 2 between the two acronyms, BTP and BTCP,
 3 right?
 4 A. Yes.
 5 Q. The C stands for cancer?
 6 A. Correct.
 7 Q. And within the company, it
 8 was understood that BTP meant
 9 breakthrough pain and BTCP meant
 10 breakthrough cancer pain, correct?
 11 MS. HILLYER: Objection.
 12 Objection to form.
 13 BY MS. RUANE:
 14 Q. In your experience with the
 15 company, you would use the phrase BTP to
 16 reference breakthrough pain and BTCP to
 17 reference breakthrough cancer pain,
 18 correct?
 19 MS. HILLYER: Objection to
 20 form.
 21 THE WITNESS: BTP, we
 22 often -- in this situation, this
 23 shows the two, but oftentimes we
 24 got a little lazy with the BTP,

1 to convey with this managed care Actiq
 2 presentation was the conclusion that pain
 3 is pain, regardless of the underlying
 4 condition, correct?
 5 A. What this states is we don't
 6 treat the underlying condition. We're
 7 not treating the underlying condition.
 8 Q. But the conclusion is pain
 9 is pain, correct?
 10 A. Yes, that's what it says.
 11 Q. Because whether -- what
 12 you're suggesting there is you show
 13 studies for each to indicate that whether
 14 you're treating breakthrough cancer pain
 15 or another type of pain, what you're
 16 treating is the pain itself, correct?
 17 A. Treating pain, correct.
 18 Q. And that is a discussion of
 19 the use of Actiq for something other than
 20 breakthrough cancer pain, correct?
 21 MS. HILLYER: Objection to
 22 the form. Mischaracterizes the
 23 document.
 24 THE WITNESS: Why don't you

1 state it a different way?

2 BY MS. RUANE:

3 Q. Sure.

4 The title that's in bold and
5 underlined there, Why Providers Want to
6 (Or Should) Have Access to Actiq, did I
7 read that correctly?

8 A. Yes, you did.

9 Q. So what we're talking about
10 with this document that you also referred
11 to as a managed care Actiq presentation
12 is a presentation on the drug Actiq,
13 correct?

14 A. Correct.

15 Q. And one of the bullet points
16 below that talks about the use of studies
17 to be included to reach the conclusion,
18 pain is pain --

19 A. I see that, yep.

20 Q. -- correct?

21 A. That's what it says, yes.

22 Q. And so the proposal here is
23 for a promotional document to be used in
24 managed care presentations discussing the

1 use of Actiq for something other than
2 breakthrough cancer pain, correct?

3 A. Based on --

4 MS. HILLYER: Object to the
5 form.

6 BY MS. RUANE:

7 Q. That's a correct statement?

8 A. Based on what I'm reading.

9 I have no recollection as to whether we
10 actually put this deck together. Maybe
11 you have a copy of it.

12 It may not have -- it may
13 not have ended up going through our
14 approval process in this format. So I
15 don't know.

16 Q. So my question is a little
17 different, just based on this document.

18 A. Sure.

19 Q. And I understand the
20 distinction. I appreciate that.

21 A. Okay.

22 Q. What you were proposing, on
23 October 15th, 2004, was a managed care
24 Actiq presentation to promote the use of

1 Actiq for something other than
2 breakthrough cancer pain, utilizing the
3 phrase "pain is pain," correct?

4 A. I want to make a distinction
5 between promote -- health plans do not
6 prescribe medications. This was at a
7 time in which, early on, Actiq was not
8 managed by plans, often it was just
9 available.

10 There was a trend to move
11 towards managing -- and when I say
12 "manage," I'm talking about what we said
13 earlier, prior authorizations and
14 criteria.

15 As a result of this, many
16 patients who doctors deemed appropriate
17 were on medications such as Actiq for
18 what they deemed appropriate, whether it
19 be noncancer pain, and that's their
20 prerogative.

21 So this was an effort,
22 albeit looking at it now, I don't know if
23 it ever made it to fruition, to establish
24 what the plan is, again, keeping in mind,

1 plans were not experts on pain
2 management. The majority of products
3 available for pain management were
4 generics, and plans don't pay a whole lot
5 of attention until branded products are
6 available.

7 And with Actiq, it was
8 highly managed across the board, it
9 evolved into that situation. Ultimately,
10 with Fentora it was the same way.

11 Q. So with this presentation,
12 your proposal was to present to managed
13 care entities advocating or explaining
14 why providers want to or should have
15 access to Actiq for something other than
16 breakthrough cancer pain, correct?

17 MS. HILLYER: Objection to
18 form.

19 THE WITNESS: I prefer the
20 word "explaining."

21 BY MS. RUANE:

22 Q. Then let me ask it again.

23 The managed care Actiq
24 presentation that you were describing

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1 here was a proposal to explain to managed
 2 care entities why providers want to or
 3 should have access to Actiq for something
 4 other than breakthrough cancer pain,
 5 correct?
 6 A. That's what it states.
 7 Q. You agree? That's a correct
 8 statement?
 9 A. That's exactly what it says.
 10 Q. Okay.
 11 MS. RUANE: All right.
 12 Let's take a quick break.
 13 VIDEO TECHNICIAN: Going off
 14 the record. 11:39 a.m.
 15 - - -
 16 (Whereupon, a brief recess
 17 was taken.)
 18 - - -
 19 VIDEO TECHNICIAN: We're
 20 back on record at 11:51 a.m.
 21 BY MS. RUANE:
 22 Q. I'm going to hand you
 23 Exhibit-10.
 24 - - -

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1 of the Actiq MCO dossier.
 2 Do you see that?
 3 A. Yes.
 4 Q. What are NAMs?
 5 A. National account managers.
 6 Q. And at that point, you were
 7 a national account manager, in 2006?
 8 A. No.
 9 Q. No, you weren't.
 10 A. I was a manager.
 11 Q. Got it.
 12 You'll see on the
 13 attachments, just to the extent it's
 14 helpful to you --
 15 A. Yes.
 16 Q. -- you're listed on both of
 17 them.
 18 Those are the attachments
 19 for the individuals who should receive a
 20 copy of the Actiq dossier.
 21 Do you see that?
 22 MS. HILLYER: Objection to
 23 form.
 24 THE WITNESS: Yes.

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1 (Whereupon, Teva-Bearer
 2 Exhibit-10,
 3 TEVA_MDL_A_10105779-782, was
 4 marked for identification.)
 5 - - -
 6 MS. RUANE: For the record,
 7 this is TEVA_MDL_A_10105779
 8 through 782.
 9 MS. HILLYER: Are they
 10 different --
 11 MS. RUANE: Those are -- I'm
 12 sorry. And then -- so the
 13 native -- if you look at 782, it's
 14 the native attachment for the
 15 sheets behind that. They are the
 16 exhibits -- or the attachments to
 17 the e-mail. Does that make sense?
 18 MS. HILLYER: Yes.
 19 MS. RUANE: Okay.
 20 THE WITNESS: Okay.
 21 BY MS. RUANE:
 22 Q. This is quick.
 23 This is an e-mail showing
 24 that all the NAMs should receive a copy

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1 MS. HILLYER: Go ahead.
 2 THE WITNESS: I'm sorry,
 3 you're asking me to look at the
 4 list -- the roster?
 5 BY MS. RUANE:
 6 Q. You see your name is on the
 7 list of people to receive an Actiq
 8 dossier?
 9 A. Yes.
 10 Q. On the second page, 780, the
 11 last sentence of the first paragraph --
 12 MS. HILLYER: Take your time
 13 to look through it, if you need
 14 to.
 15 BY MS. RUANE:
 16 Q. -- indicates, There have
 17 been some updates to the Provigil white
 18 paper and we have arranged for all the
 19 NAMs to receive copies of the Provigil
 20 and Actiq white paper.
 21 Do you see that?
 22 A. Yes.
 23 Q. So let me hand you
 24 Exhibit-11.

<p style="text-align: right;">Page 141</p> <p>1 - - -</p> <p>2 (Whereupon, Teva-Bearer</p> <p>3 Exhibit-11, TEVA_CHI_00036903-930,</p> <p>4 was marked for identification.)</p> <p>5 - - -</p> <p>6 MS. HILLYER: Are we done</p> <p>7 with 10?</p> <p>8 MS. RUANE: I think so.</p> <p>9 For the record, this is</p> <p>10 TEVA_CHI_00036903 through 930.</p> <p>11 BY MS. RUANE:</p> <p>12 Q. This is an Actiq managed</p> <p>13 care dossier, correct?</p> <p>14 A. Yes.</p> <p>15 Q. Are you familiar with this</p> <p>16 type of document?</p> <p>17 A. Yes.</p> <p>18 Q. These are documents provided</p> <p>19 to managed care entities?</p> <p>20 A. Upon request of medical</p> <p>21 services.</p> <p>22 Q. If a managed care entity</p> <p>23 requested information about Actiq, it</p> <p>24 would -- this managed care dossier would</p>	<p style="text-align: right;">Page 142</p> <p>1 be provided to them, correct?</p> <p>2 A. Through medical services,</p> <p>3 correct.</p> <p>4 Q. I assume that there were</p> <p>5 times where managed care entities would</p> <p>6 request, through medical services, a copy</p> <p>7 of the dossier, which is why it was</p> <p>8 created?</p> <p>9 A. Correct.</p> <p>10 Q. This was the Actiq dossier,</p> <p>11 correct?</p> <p>12 A. That's what it says, yes.</p> <p>13 Q. And I'll tell you, there's</p> <p>14 three modules, they are divided up.</p> <p>15 A. I haven't seen this in</p> <p>16 years, so I'm glad you told me that.</p> <p>17 Q. You would have seen it at</p> <p>18 the time, correct?</p> <p>19 A. If it was sent to me, I saw</p> <p>20 it, yes.</p> <p>21 Q. And in your interactions</p> <p>22 with managed care entities during this</p> <p>23 time frame, you would have spoken with</p> <p>24 them about the dossier, if they had</p>
<p style="text-align: right;">Page 143</p> <p>1 requested it, correct?</p> <p>2 MS. HILLYER: Objection to</p> <p>3 form. Assuming facts not in</p> <p>4 evidence.</p> <p>5 THE WITNESS: No. No. They</p> <p>6 would have -- if they asked for a</p> <p>7 dossier, we would send in a</p> <p>8 request to medical services,</p> <p>9 period. That's all you can say.</p> <p>10 You're not allowed to discuss</p> <p>11 what's in the dossier. It's not a</p> <p>12 promotional piece.</p> <p>13 BY MS. RUANE:</p> <p>14 Q. I'm sorry, what did you say</p> <p>15 about promotional piece?</p> <p>16 A. This is not a promotional</p> <p>17 piece. This is a medical piece.</p> <p>18 Q. And in this document, on the</p> <p>19 second page -- there's little page</p> <p>20 numbers at the bottom, I'm going to use</p> <p>21 those, just for ease of reference.</p> <p>22 A. I see. And what page did</p> <p>23 you say? I'm sorry.</p> <p>24 Q. 2.</p>	<p style="text-align: right;">Page 144</p> <p>1 A. 2, got it.</p> <p>2 Q. This document indicates, in</p> <p>3 that last paragraph, Breakthrough pain,</p> <p>4 defined as a transitory flare of</p> <p>5 moderate-to-severe pain that occurs in</p> <p>6 patients with otherwise stable,</p> <p>7 controlled, persistent pain, is a</p> <p>8 prevalent form of pain in patients with</p> <p>9 malignant and nonmalignant diseases.</p> <p>10 Do you see that?</p> <p>11 A. Yes.</p> <p>12 Q. I'm looking back at 7.</p> <p>13 MS. HILLYER: Do you want</p> <p>14 her to?</p> <p>15 MS. RUANE: Yes.</p> <p>16 BY MS. RUANE:</p> <p>17 Q. If you'll pull up Exhibit-7</p> <p>18 as well.</p> <p>19 MS. HILLYER: Give me a</p> <p>20 second, please.</p> <p>21 Okay, we're there.</p> <p>22 BY MS. RUANE:</p> <p>23 Q. Exhibit-7 was an e-mail</p> <p>24 chain regarding feedback on the Actiq</p>

1 white paper.
 2 Do you see that?
 3 A. Yes.
 4 Q. And the suggestion, under
 5 Module 1, which we're looking at Module
 6 1, right?
 7 A. So based on what I'm seeing
 8 here today, these are two different --
 9 two different pieces.
 10 This is a dossier. This is
 11 a white paper.
 12 Q. Okay. That's -- I'm going
 13 to ask you --
 14 A. As I recall. I mean, we
 15 would not call a dossier a white paper.
 16 Q. So I want to make sure I'm
 17 clear on something as it relates to that.
 18 On Number 2, this Actiq
 19 white paper feedback e-mail --
 20 A. Yes.
 21 Q. -- if you look at Number 2D,
 22 the revision that they ended up with --
 23 A. Right.
 24 Q. -- indicates -- and we're

1 Q. Let's look just at the part
 2 that references, Patients with malignant
 3 and nonmalignant diseases.
 4 The phrase "patients with
 5 malignant and nonmalignant diseases"
 6 appears in both Exhibit-7 and 11,
 7 correct?
 8 A. It's unfortunate -- correct.
 9 It's unfortunate these aren't referenced,
 10 because in many documents you'll have
 11 inconsistent approaches to the way -- I
 12 mean, in anything, as long as it's
 13 sourced.
 14 This is a very old dossier
 15 layout. Currently, you have to annotate
 16 the entire thing and then you have
 17 actual, you know, verbatim. So this was
 18 sort of in the beginning. This is not
 19 the traditional format that is used
 20 today. So I will just say that part.
 21 So it wouldn't be uncommon
 22 for one document to have -- as long --
 23 because definition can come from one
 24 source but reads differently than

1 looking at Exhibit-7 right now, so we're
 2 talking about the white paper, right?
 3 A. Yes.
 4 Q. And it indicates,
 5 Breakthrough pain, defined as a transient
 6 flare in pain of moderate-to-severe
 7 intensity occurring in conjunction with
 8 persistent pain, is a prevalent form of
 9 pain in patients with malignant and
 10 nonmalignant diseases.
 11 Correct?
 12 A. That's what it says.
 13 Q. Okay. And that's the same
 14 language that's included in the dossier,
 15 correct?
 16 MS. HILLYER: Objection to
 17 form. It's not. I mean, it's
 18 not.
 19 BY MS. RUANE:
 20 Q. With the exception of
 21 "transitory" to "transient"?
 22 MS. HILLYER: There's some
 23 different wording, but --
 24 BY MS. RUANE:

1 another. So I can't really comment.
 2 Q. But what we do know, because
 3 we have the documents before us, is that
 4 the Exhibit-11, the dossier, references
 5 breakthrough pain as a prevalent form of
 6 pain in patients with malignant and
 7 nonmalignant diseases, correct?
 8 A. Yes.
 9 Q. And based on Exhibit-7, we
 10 also know that, at least the feedback for
 11 the Actiq white paper, and the conclusion
 12 that Susan, in medical services, reached
 13 was to reference breakthrough pain as a
 14 prevalent form of pain in patients with
 15 malignant and nonmalignant diseases,
 16 correct?
 17 A. Yes.
 18 Q. Okay. Just a few more
 19 questions on Exhibit-11.
 20 On Page 10 of Exhibit-11,
 21 the second -- or, I guess, the first full
 22 paragraph starts, For many patients.
 23 Do you see that?
 24 A. I do see that.

1 Q. And the first sentence there
2 says, For many patients, no causative
3 factor can be found for the chronic pain
4 and no specific diagnosis can be made.
5 Do you see that?
6 A. Yes.
7 Q. Do you agree that is not
8 referencing breakthrough cancer pain,
9 correct?
10 A. It does not mention
11 breakthrough cancer pain.
12 Q. It mentions chronic pain
13 with no causative factor found, correct?
14 A. Correct.
15 Q. If you go on in the middle
16 of the paragraph, there's a sentence that
17 starts, However, experts in pain
18 management have recommended that the
19 primary goal of patient care for these
20 patients should be symptom control,
21 including the use of opioids where
22 appropriate.
23 Do you see that?
24 A. Yes.

1 that patients with no causative factor
2 for their chronic pain should be treated
3 with opioids?
4 MS. HILLYER: Objection to
5 form. Mischaracterizes the
6 document.
7 THE WITNESS: You'll have to
8 restate that. I don't agree with
9 what you just said.
10 BY MS. RUANE:
11 Q. We know that Cephalon was
12 using a dossier and published a dossier
13 that discussed opioid treatment for
14 patients with chronic pain where no
15 specific diagnosis can be made, correct?
16 MS. HILLYER: Objection to
17 form.
18 You can answer.
19 THE WITNESS: So I didn't
20 create this document. But what I
21 will tell you is, for the record,
22 patients who are prescribed a --
23 either Fentora or Actiq, were --
24 had chronic pain, they were on

1 Q. And then the next -- there's
2 citations.
3 So there were some cites in
4 this white paper?
5 A. I see that. I see that.
6 Q. In the dossier, excuse me.
7 A. Yeah. Good.
8 Q. And then it references,
9 Several professional organizations have
10 published guidelines to guide
11 practitioners in this area.
12 Do you see that?
13 A. I see that.
14 Q. And it references
15 specifically the American Academy of Pain
16 Medicine, the American Pain Society, and
17 the Federation of State Medical Boards of
18 the United States.
19 Do you see that?
20 A. I see that.
21 Q. So based on Exhibit-11, we
22 know that Cephalon, in its dossier, was
23 referring back to societies, at least as
24 part of the support for the proposition

1 chronic pain medications, which
2 sometimes included opioids. So
3 this is all true.
4 This is more about chronic
5 pain and then, hopefully, it will
6 get to start talking about
7 breakthrough pain.
8 But these are chronic pain
9 patients who have been on a
10 long-acting OxyContin, something
11 of that nature, and they have
12 breakthrough episodes of which the
13 short-actings are appropriate.
14 So, to me, this is just
15 setting the stage in general, in
16 my interpretation.
17 BY MS. RUANE:
18 Q. And it is referring to
19 patients who have that chronic pain but
20 do not have cancer, correct?
21 A. It's a general statement
22 about pain.
23 Q. Yes.
24 But the beginning paragraph

1 discusses the fact that these are
 2 patients where no causative factor can be
 3 found for their chronic pain and no
 4 specific diagnosis can be made, correct?
 5 A. That's what it states.
 6 THE WITNESS: Are we
 7 finished with this one?
 8 MS. RUANE: Yes.
 9 I'm going to hand you what's
 10 been marked as Exhibit-12. This
 11 is Module 2 for the Actiq managed
 12 care dossier.
 13 - - -
 14 (Whereupon, Teva-Bearer
 15 Exhibit-12, TEVA_CHI_00036931-955,
 16 was marked for identification.)
 17 - - -
 18 BY MS. RUANE:
 19 Q. And I want to make sure I
 20 understand this right.
 21 Your testimony is, aside
 22 from reaching out to medical services to
 23 request a dossier, if that conversation
 24 was initiated by a managed care entity,

1 information in the dossier?
 2 MS. HILLYER: Objection to
 3 form.
 4 THE WITNESS: That -- no,
 5 there may be information in the
 6 dossier which would be part of
 7 what we would discuss, not
 8 specific to the dossier. So I
 9 don't think that's accurate.
 10 BY MS. RUANE:
 11 Q. With that distinction.
 12 Obviously, the dossier covers a lot of
 13 things.
 14 A. Exactly.
 15 Q. But as far as talking
 16 specifically about the dossier and the
 17 information in the dossier in front of,
 18 you know, the managed care entity, it
 19 would have been inappropriate for you or
 20 your team to discuss the details of that
 21 dossier specifically?
 22 MS. HILLYER: Objection to
 23 form.
 24 THE WITNESS: Are you asking

1 you and your team did not discuss the
 2 dossiers with the managed care entities;
 3 is that correct?
 4 A. That's correct. To my
 5 recollection, as far as the
 6 dissemination.
 7 I will say I may -- I recall
 8 at one point, I don't recall if it was
 9 for Actiq or other products, before they
 10 became electronic, which is the norm now,
 11 they were hard copies, and they were
 12 shrinkwrapped, and we were not able to
 13 even open them.
 14 And there may have been a
 15 vehicle in which an account manager,
 16 based on the shrinkwrap, could deliver
 17 it. I vaguely -- I do remember that.
 18 I don't recall what product
 19 it was, though.
 20 Q. Okay. But it would have
 21 been -- based on your training and time
 22 with the company, it would have been
 23 inappropriate for an individual to speak
 24 to the managed care entities about the

1 about the content?
 2 BY MS. RUANE:
 3 Q. Yes.
 4 A. Are you asking what is -- if
 5 the payer says, what is included, there
 6 are several sections? We would say,
 7 well, there's economic information,
 8 there's background information.
 9 Generally like that.
 10 Q. I'm asking whether, based on
 11 your earlier testimony that white papers
 12 are one thing but dossiers are another,
 13 dossiers go through medical services and
 14 you would not have spoken with managed
 15 care entities about information in the
 16 dossier.
 17 Am I -- I want to make sure
 18 I understand you correctly.
 19 A. Yes, that is the policy --
 20 MS. HILLYER: Objection.
 21 Mischaracterizes the testimony.
 22 And objection to form.
 23 You can answer.
 24 THE WITNESS: Sorry.

1 As I recall -- mind you,
2 this is a long time ago and we've
3 changed, evolved with the dossier.

4 Based on my recollection, we
5 would not have discussed the
6 contents of the dossier.

7 That's my recollection, we would
8 not have.

9 BY MS. RUANE:

10 Q. Do you have an understanding
11 of why that was the policy?

12 A. This is not a medical/legal
13 review document.

14 Q. And what do you mean by
15 that?

16 A. It's not a promotional
17 piece.

18 Q. The only documents -- am I
19 correct that the only documents your team
20 was allowed to discuss with the managed
21 care entities were promotional pieces?

22 A. That's correct.

23 Q. And am I correct that the
24 promotional pieces would have been

1 approved by medical/legal?

2 A. Yes. Although I'm not
3 remembering about the WL lefts, the
4 reprints that may have been part of that
5 back in those days.

6 Obviously, policies have
7 changed over time. So I don't recall if
8 there were any clinical reprints that
9 were approved for dissemination.

10 Q. Okay. And I appreciate
11 that. If we get there, we get there; if
12 not, no big deal.

13 But what I want to make sure
14 I understand is, when you talk about the
15 promotional piece, it appears to have
16 some significance, the phrase
17 "promotional piece." And so I want to
18 make sure I understand what that means to
19 you.

20 It sounds like what it means
21 to you is a piece that has been approved
22 by medical/legal that you can discuss
23 with the managed care entities; is that
24 correct?

1 A. Medical, legal, and
2 regulatory.

3 Q. Okay. And your memory is
4 the Actiq white paper, which I know is
5 different in your memory than what we're
6 looking at right now, but your memory is
7 the Actiq white paper was a promotional
8 piece?

9 MS. HILLYER: Objection.
10 Mischaracterizes testimony.

11 THE WITNESS: No.

12 BY MS. RUANE:

13 Q. So the Actiq white paper is
14 not a promotional piece?

15 A. My memory is based on the
16 e-mail you showed me, which shows
17 professional services.

18 And without specifically
19 remembering the details of the white
20 paper, anything that referenced
21 professional services fell under a
22 nonpromotional piece that was
23 disseminated upon request.

24 Q. Let's look at -- I gave you

1 Exhibit-12, right? Module 2.

2 MS. HILLYER: No.

3 I don't think you put it on
4 the record, if you wanted to.

5 MS. RUANE: Sorry. Thank
6 you.

7 BY MS. RUANE:

8 Q. We're now looking at
9 Exhibit-12, which is TEVA_CHI_00036931.

10 Again, there's little
11 numbers on the document, I'm just going
12 to use those because it's easier.

13 A. I see.

14 Q. On Page 3 of the document,
15 the last paragraph, about halfway
16 through, there's a sentence that starts
17 with, Addiction?

18 A. Yes.

19 Q. It says, Addiction, a
20 disease characterized by behaviors such
21 as compulsion, harm to the user or
22 continued use despite harm, is uncommon
23 in patients using opioids for a medical
24 condition.

1 Do you see that?

2 A. I see that.

3 Q. What scientific support is

4 there for that statement?

5 MS. HILLYER: Objection.

6 Lack of foundation. Calls for

7 speculation.

8 BY MS. RUANE:

9 Q. Do you see any there?

10 A. I can't answer that

11 question.

12 Q. You had mentioned earlier

13 that sometimes there's citations to the

14 studies supporting statements.

15 Do you see any citation

16 there or reference point?

17 A. Nope.

18 Q. Do you know, just based on

19 your personal experience in managed care

20 with opioids over time, any -- do you

21 have any support, any scientific support,

22 that you're aware of for that statement?

23 MS. HILLYER: Objection.

24 Calls for speculation. Lack of

1 foundation.

2 THE WITNESS: I don't have

3 an opinion about that.

4 BY MS. RUANE:

5 Q. Do you believe that

6 addiction is uncommon in patients using

7 opioids for medical conditions?

8 MS. HILLYER: Objection to

9 form.

10 THE WITNESS: I'm not a

11 physician.

12 BY MS. RUANE:

13 Q. You have no opinion one way

14 or another?

15 A. No.

16 Q. Page 22 references

17 pseudoaddiction.

18 Do you see that?

19 A. Yes, I do.

20 Q. Are you familiar with the

21 term "pseudoaddiction"?

22 A. I don't recall.

23 Q. You agree it's a term that

24 was used in documents provided by the

1 company?

2 MS. HILLYER: Objection to

3 form.

4 THE WITNESS: I don't

5 remember seeing pseudoaddiction in

6 any of the pieces that we used

7 with payers.

8 It may have been, I just

9 don't recall.

10 BY MS. RUANE:

11 Q. Pseudoaddiction is in

12 Exhibit-12, which was provided to managed

13 care payers upon request?

14 MS. HILLYER: Objection.

15 Assumes facts not in evidence.

16 BY MS. RUANE:

17 Q. I mean, you see it in

18 Exhibit-12, right?

19 A. I said I don't recall

20 because this is the first time I've seen

21 this in how many years.

22 But your statement is

23 correct. In bold words -- letters, it

24 says, Pseudoaddiction. And it's in a

1 module that would have been received by

2 payers.

3 Q. And pseudoaddiction there

4 states, Addiction should be distinguished

5 from pseudoaddiction, which is

6 characterized by drug-seeking behaviors

7 caused by unrelieved pain. Some patients

8 with unrelieved or untreated pain may be

9 aggressive in requesting additional

10 analgesics. When such requests are not

11 related to psychological beliefs nor to

12 psychic effects, but rather to unrelieved

13 pain, the appropriate response is

14 improved pain management.

15 Do you see that?

16 A. I see that.

17 Q. Do you see any scientific

18 support for that statement?

19 MS. HILLYER: Objection. Do

20 you mean in the document?

21 MS. RUANE: In the document.

22 THE WITNESS: I don't see

23 anything.

24 BY MS. RUANE:

1 Q. Do you know any
2 scientific -- I'm sorry, I didn't mean to
3 interrupt you.

4 A. I was answering. You just
5 couldn't hear me.

6 Q. Sorry. Go ahead.

7 A. I do not see a reference on
8 this document.

9 Q. Do you know of any
10 scientific support for the theory of
11 pseudoaddiction?

12 MS. HILLYER: Objection to
13 form.

14 You can answer.

15 THE WITNESS: I'm not
16 familiar with this, period.

17 BY MS. RUANE:

18 Q. You're not familiar with
19 pseudoaddiction?

20 A. So I can't answer your
21 question.

22 Q. Given your role with managed
23 care entities assessing reimbursement
24 issues related to Actiq and then

1 Fentora --

2 A. Sure.

3 Q. -- did you receive education
4 and training on issues related to
5 addiction or abuse of opioids?

6 A. Sure. I just don't recall
7 if this is what I stated.

8 Q. And what type of training
9 and education did you receive?

10 A. There were training modules
11 that all the account managers were
12 required to complete on the disease
13 state, misuse, abuse, diversion, all the
14 things that we're talking about, as far
15 as what you're referring to here, in
16 addition to the mechanism of action of
17 the product, as with any training on a
18 product that any pharmaceutical company
19 would provide, not unlike that.

20 Q. And during your time working
21 with managed care entities on the
22 products Actiq and then Fentora, did you
23 come to any conclusions about the issues
24 of abuse associated with those drugs?

1 MS. HILLYER: Objection to
2 form.

3 THE WITNESS: No
4 conclusions.

5 BY MS. RUANE:

6 Q. Sitting here today, have you
7 reached a conclusion as to whether
8 there's an opioid epidemic?

9 MS. HILLYER: Objection to
10 form.

11 THE WITNESS: A conclusion,
12 no.

13 BY MS. RUANE:

14 Q. Page 23 of Exhibit-12 --

15 A. I'm sorry, you said 23?

16 Q. Yes, just the next page.

17 The last sentence in the
18 first paragraph indicates, Similarly, the
19 risk of abuse is low in patients with
20 nonmalignant pain, though there is less
21 experience in this patient population.

22 Do you see that?

23 A. I'm sorry, I wasn't
24 following where it is.

1 Q. Up at the top.

2 A. Up at the top, sorry.

3 Q. And then right below that,
4 under, Managing the risk of opioid abuse,
5 in that first sentence, it indicates,
6 Although it is uncommon for chronic pain
7 patients to abuse opioid medications,
8 there is a potential risk associated with
9 the use of all opioids.

10 Do you see that?

11 A. I see that.

12 Q. Do you know of any
13 scientific -- well, strike that.

14 First, let me ask you, do
15 you see any scientific support cited in
16 Exhibit-12 for those statements?

17 A. No.

18 Q. Do you personally have any
19 scientific support for the idea that it's
20 uncommon for chronic pain patients to
21 abuse opioid medications?

22 MS. HILLYER: Objection to
23 form.

24 THE WITNESS: Are you saying

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1 do I have an opinion?
 2 BY MS. RUANE:
 3 Q. Yes.
 4 A. I don't have an opinion.
 5 Q. This is information that was
 6 created by, I guess at this time, by
 7 Cephalon, correct?
 8 A. It was -- yes.
 9 Q. And Cephalon was also the
 10 company that was creating the modules
 11 used to train you all on Actiq, correct?
 12 MS. HILLYER: Objection to
 13 form.
 14 THE WITNESS: I was not
 15 involved with the sales training.
 16 I don't know who developed that.
 17 BY MS. RUANE:
 18 Q. But Cephalon was the -- I
 19 mean, you didn't receive training on
 20 issues of opioids and potential abuse or
 21 diversion from anyone outside the
 22 company, correct?
 23 A. I don't -- no. No, I don't
 24 recall.

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1 are different managed care entities,
 2 right?
 3 You've got Blue Cross and
 4 Blue Shield of Alabama and then Regents.
 5 And you mentioned there's probably over
 6 100 in the nation, but these are some you
 7 all dealt with, correct?
 8 A. Correct.
 9 Q. Under Blue Cross and Blue
 10 Shield of Alabama, the description under
 11 primary purpose of the clinical
 12 presentation, toward the bottom of the
 13 page, this is a document that's providing
 14 some managed care Medicaid scenarios for
 15 an Actiq speaker training, correct?
 16 A. Yes.
 17 Q. And the Actiq speaker
 18 training would be a training of -- well,
 19 strike that.
 20 Who -- what speakers were
 21 being trained?
 22 A. I don't recall.
 23 Q. Are they Cephalon employees
 24 or are they the key opinion leaders that

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1 Q. So it's a correct statement
 2 that your training on issues of potential
 3 abuse, diversion of opioids would have
 4 occurred through your employment with
 5 Cephalon and then Teva, correct?
 6 A. That's a true statement.
 7 MS. RUANE: I'm going to
 8 hand you what's been marked as
 9 Exhibit-13. And for the record,
 10 this is TEVA_MDL_A_03272381.
 11 - - -
 12 (Whereupon, Teva-Bearer
 13 Exhibit-13,
 14 TEVA_MDL_A_03272381-391, was
 15 marked for identification.)
 16 - - -
 17 BY MS. RUANE:
 18 Q. This is an e-mail you sent
 19 to Terry Terifay regarding an upcoming
 20 Actiq speaker training.
 21 A. Yes.
 22 Q. And Page 382, that second
 23 page, what you'll see, as you go through
 24 it, there's different -- I assume these

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1 we discussed earlier, do you know?
 2 A. Speakers -- say the question
 3 one more time.
 4 Q. Sure.
 5 The speaker training, would
 6 it be for employees of Cephalon who are
 7 going to do a managed care presentation?
 8 A. I don't recall.
 9 Q. Under the primary purpose of
 10 the clinical presentation, the second
 11 bullet point there indicates, Explain
 12 different utilities for Actiq and reasons
 13 why pain management specialists are
 14 prescribing it for noncancer breakthrough
 15 pain.
 16 Do you see that?
 17 A. Yes.
 18 Q. And that's something that
 19 would happen at these meetings with
 20 managed care entities, correct?
 21 MS. HILLYER: Objection to
 22 form.
 23 THE WITNESS: This -- the
 24 way -- you're asking if this

<p style="text-align: right;">Page 173</p> <p>1 presentation was for -- to payers? 2 Is that what you're -- I'm sorry. 3 BY MS. RUANE: 4 Q. Let's back up and make sure 5 we're -- 6 A. Let's make sure we're on the 7 same page. 8 Q. -- on the same page. 9 These are managed care 10 Medicaid scenarios -- 11 A. Yes. 12 Q. -- provided by national 13 account managers -- 14 A. Yes. 15 Q. -- for the upcoming Actiq 16 speaker training? 17 A. Yes. 18 Q. Okay. So this is going to 19 be for a speaker training meeting? 20 A. Right. 21 Q. Presumably those speakers, 22 their role is then going to be to go out 23 and talk to managed care entities, 24 correct?</p>	<p style="text-align: right;">Page 174</p> <p>1 A. No, I don't interpret it 2 this way. 3 Q. What would the speaker 4 training be for? 5 A. Based on what I'm reading 6 here, having -- not recalling this, 7 the -- 8 MS. HILLYER: Then 9 objection. Calls for speculation. 10 THE WITNESS: Yeah, I really 11 don't know. 12 BY MS. RUANE: 13 Q. Let's back up a little bit. 14 A. Okay. 15 Q. Look, for example, on Blue 16 Cross and Blue Shield of Alabama, the 17 second heading there is, Key 18 decision-makers who will be attending the 19 clinical presentation. 20 Do you see that? 21 A. Yes, I do. Yep. Yep. 22 Q. Is that helpful? 23 A. Yes. 24 Q. So are we now on the same</p>
<p style="text-align: right;">Page 175</p> <p>1 page, that this is information provided 2 in advance of meetings with managed care 3 entities? 4 A. Hold off. Let me look. 5 That's the way I would 6 interpret this. 7 Q. And down below, under 8 primary purpose, there's the bullet point 9 for explaining different utilities for 10 Actiq and reasons why pain management 11 specialists are prescribing it for 12 noncancer breakthrough pain, correct? 13 A. That's what it says. 14 Q. Okay. And you were aware of 15 this at the time, because these were 16 scenarios that you sent to Terry Terifay, 17 correct? 18 A. Yes. 19 Q. The bullet point below that 20 indicates that another purpose of the 21 presentation was to convince the plan to 22 consider coverage for any of the above 23 uses, correct? 24 A. I'm sorry, where are you</p>	<p style="text-align: right;">Page 176</p> <p>1 here? 2 Q. Sorry. Third bullet point 3 down on primary purpose. 4 A. Yes, that's what it says. 5 Sorry. 6 Q. So one of the goals, when 7 you're meeting with these managed care 8 entities, is to convince the plan to 9 consider coverage for any of the above 10 uses, and that's referring to noncancer 11 breakthrough pain uses, correct? 12 A. That's what it says. 13 Q. That was one of the goals of 14 you and your team when you were meeting 15 with managed care entities for Actiq and 16 then subsequently for Fentora, correct? 17 MS. HILLYER: Objection to 18 form. 19 THE WITNESS: In general. 20 We had different objectives for 21 each plan, depending on the 22 situation, because each plan payer 23 is different. 24 BY MS. RUANE:</p>

1 Q. For Blue Cross and Blue
2 Shield of Alabama --
3 A. I don't have any direct
4 knowledge of that. That wasn't a part of
5 my area.

6 That's why I'm hesitating
7 quite a bit, because these are not
8 plans -- I was trying to figure -- that I
9 have direct knowledge of.

10 Q. And the reason -- I mean, in
11 fairness to you, I understand it was a
12 long time ago, so we'll work through it
13 together.

14 But you are -- you were the
15 one that sent this e-mail, right?

16 A. Correct.

17 Q. And one of the things that
18 you just know, in addition to the e-mail,
19 from your own personal experience is that
20 many times when you were meeting with
21 managed care entities, one of the things
22 you were doing was working to convince
23 them to consider coverage for something
24 other than breakthrough cancer pain,

1 diagnosis, it was up to the doctor
2 as to what product was
3 appropriate.

4 So I view this as more of an
5 education, because many times when
6 restrictions come quickly, it
7 causes a disruption for the
8 patient in treatment.

9 So a lot of this was an
10 education process. Many of these
11 plans we had not engaged with on a
12 regular basis for Actiq.

13 BY MS. RUANE:

14 Q. And so the goal was, in
15 those cases, to convince plans to
16 consider coverage for something other
17 than breakthrough cancer pain, correct?

18 A. The goal is --

19 MS. HILLYER: Hold on.
20 Objection to form. And asked and
21 answered.

22 You can answer again.

23 BY MS. RUANE:

24 Q. I mean, at least as it

1 correct?

2 MS. HILLYER: Objection to
3 form.

4 THE WITNESS: We presented
5 information. As I stated before,
6 many plans -- I don't know the
7 details around these -- did not
8 have a lot of rigor behind Actiq
9 early on.

10 By the time I joined the
11 company in 2004 was when payers
12 were starting to take a look at
13 opioids. And sometimes by just
14 default they would make decisions
15 on coverage. I can't speak to
16 what specifically they were.

17 As I mentioned earlier,
18 coverage criteria goes beyond
19 indication. There are many other
20 requirements in coverage criteria.

21 Additionally, many patients
22 were currently on, as a doctor
23 deemed appropriate, whether it --
24 whether they -- depending on the

1 relates to this Blue Cross and Blue
2 Shield of Alabama.

3 Let me ask a different
4 question.

5 You would agree that this
6 document, which you provided to Terry
7 Terifay, indicates that one of the
8 primary purposes of the clinical
9 presentation is to provide -- was to,
10 strike that -- to convince the plan to
11 consider coverage for any of the above
12 uses, which refers to noncancer
13 breakthrough plan?

14 MS. HILLYER: Objection to
15 the form. Lack of foundation.
16 And calls for speculation. She
17 said she didn't cover this
18 account.

19 THE WITNESS: I don't have
20 direct knowledge of Blue Cross
21 Blue Shield of Alabama.

22 BY MS. RUANE:

23 Q. Let me ask a different
24 question.

1 We know, and we talked about
2 in the first hour of this deposition, the
3 fact that you were -- as a national
4 account manager and then subsequently as
5 you became a director, you met with
6 managed care entities, right?

7 A. Correct.

8 Q. And one of the things you
9 did, during your time as a national
10 account manager at Cephalon, was to meet
11 with managed care entities, correct?

12 A. Yes.

13 MS. HILLYER: Asked and
14 answered.

15 BY MS. RUANE:

16 Q. And during that time, one of
17 the products that you would discuss was
18 Actiq, correct?

19 A. Correct.

20 Q. And, obviously, it depends
21 on the plan and what their coverage is --

22 A. Right.

23 Q. -- at that time, but one of
24 the things that you did was work with

1 plans who didn't have the coverage
2 criteria for Actiq that would have been
3 most beneficial for purposes of increased
4 prescriptions, would be to work with
5 those plans on convincing them to
6 consider coverage for something other
7 than breakthrough cancer pain, correct?

8 MS. HILLYER: Objection to
9 form.

10 BY MS. RUANE:

11 Q. That's a thing that
12 happened, isn't it?

13 MS. HILLYER: Objection to
14 form.

15 THE WITNESS: A result --

16 MS. HILLYER: Go ahead.

17 THE WITNESS: As I stated
18 previously, much of the
19 interaction, whether it be
20 promotional or from medical, was
21 an educational process where many
22 patients, whatever the physician
23 deemed appropriate, prescribed
24 Actiq for their patients.

1 Part of what we discussed
2 was the broad spectrum of pain
3 management, et cetera, as you've
4 seen in all of these documents.

5 If, in fact, they did change
6 criteria, the result would be the
7 patient would have access
8 ultimately at that point, to your
9 point, and Cephalon would have the
10 benefit of the sale of that
11 product. So that's an accurate
12 statement.

13 BY MS. RUANE:

14 Q. And it's also an accurate
15 statement that during those times that
16 you were talking to the managed care
17 entities, you were talking to them about
18 the broad spectrum of pain, which
19 included pain beyond breakthrough cancer
20 pain, correct?

21 MS. HILLYER: Objection to
22 form.

23 THE WITNESS: Honestly, I
24 don't remember engaging with a

1 plan specifically to the question
2 that you've asked me. I really
3 don't recall specifically.

4 Many times, plans would
5 request information.

6 BY MS. RUANE:

7 Q. And based on the fact that
8 you've been with the company, you know,
9 for over a decade -- I understand a lot
10 of this was a long time ago.

11 But you've just described
12 for us how you would speak to them about
13 the broad spectrum of pain; that was part
14 of the job, was to educate them on the
15 broad spectrum of pain.

16 And you agree that broad
17 spectrum of pain went beyond breakthrough
18 cancer pain, correct?

19 MS. HILLYER: Objection to
20 form. It mischaracterizes
21 testimony.

22 BY MS. RUANE:

23 Q. That's a correct statement,
24 isn't it?

<p style="text-align: right;">Page 185</p> <p>1 MS. HILLYER: I made my 2 objection. 3 She can answer the question. 4 THE WITNESS: Again, pain 5 management was not something 6 familiar to payers. If I -- if I 7 had a conversation with a plan, it 8 would have been based on an 9 approved document that may have 10 had the disease background on pain 11 management. Because, again, this 12 is for patients suffering from 13 chronic pain who have breakthrough 14 episodes. So it's very relevant 15 to talk about chronic pain, 16 spectrum of pain, and talk about 17 breakthrough episodes specific to 18 our label, which would then 19 include cancer patients. 20 BY MS. RUANE: 21 Q. And the conversation about 22 the chronic pain and the breakthrough 23 pain would not necessarily be limited to 24 cancer patients, correct?</p>	<p style="text-align: right;">Page 186</p> <p>1 MS. HILLYER: Objection to 2 form. 3 THE WITNESS: I don't recall 4 the documents -- maybe you'll 5 provide them to me -- the 6 documents that we used. I 7 honestly don't remember the 8 content of those. 9 A lot of what we do with 10 payers is educate on disease 11 state, as I've stated before. 12 This is very common in current 13 products that we promote now. 14 It's very common to talk about 15 standard of care. It's very 16 common to talk about chronic and 17 acute medications. 18 It sets the foundation for 19 the discussion with a payer. 20 BY MS. RUANE: 21 Q. Okay. If you look on 22 Exhibit-13, on Page 82 at the bottom, it 23 references several objections from the 24 plan, including the concern over abuse</p>
<p style="text-align: right;">Page 187</p> <p>1 and diversion of opioids. 2 Do you see that? 3 A. I saw it previously. Is 4 this 82? 5 Q. 82, yes. At the very 6 bottom. 7 A. Right. Sorry. 8 Q. Do you see that? 9 A. Yep, yep. 10 Q. On Page 85, the second 11 bullet point indicates, Physicians are 12 afraid of opioid use. 13 A. You're saying 85? 14 Q. Yes. 85. 15 A. Yes. 16 Q. Do you see that? 17 A. Yes, that's what it says. 18 Q. The last two -- well, strike 19 that. Let me ask this first. 20 Do you recall receiving 21 feedback from managed care entities 22 regarding fears of opioids and abuse as a 23 reason not to expand the criteria? 24 A. Schedule II products, many</p>	<p style="text-align: right;">Page 188</p> <p>1 of them. So, of course, we -- they would 2 discuss any scheduled product. 3 Q. And so it was -- generally 4 speaking, it was a conversation you would 5 have with these managed care entities, 6 because they would bring up the concerns 7 associated with Schedule II products? 8 MS. HILLYER: Objection to 9 form. 10 THE WITNESS: Not -- you're 11 making a broad statement, and I 12 can't speak to every conversation 13 that I had with every plan. 14 Misuse, abuse and diversion, 15 we take a responsibility as a 16 company, we are certainly aware of 17 that. 18 So if they asked the 19 question, we would have a 20 conversation about it. 21 BY MS. RUANE: 22 Q. And as a company, misuse, 23 abuse and diversion are things that the 24 company was aware of and you were aware</p>

<p style="text-align: right;">Page 189</p> <p>1 of, correct?</p> <p>2 MS. HILLYER: Objection.</p> <p>3 Calls for speculation.</p> <p>4 THE WITNESS: We're aware of</p> <p>5 because it's a Schedule II</p> <p>6 product.</p> <p>7 BY MS. RUANE:</p> <p>8 Q. And because of that fact,</p> <p>9 you found yourself speaking to managed</p> <p>10 care entities about their questions</p> <p>11 associated with a Schedule II product and</p> <p>12 use, abuse and diversion, correct?</p> <p>13 A. I don't recall any specific</p> <p>14 questions around -- I just don't recall</p> <p>15 any specific questions that I received</p> <p>16 and having that conversation.</p> <p>17 Q. But you would agree that</p> <p>18 they did occur, at least sometimes,</p> <p>19 because we've looked at a couple of them</p> <p>20 in this document, correct?</p> <p>21 MS. HILLYER: Objection.</p> <p>22 Calls for speculation. Lack of</p> <p>23 foundation.</p> <p>24 THE WITNESS: You do realize</p>	<p style="text-align: right;">Page 190</p> <p>1 I did not create this document?</p> <p>2 This was a compilation of</p> <p>3 what was sent to me, and I</p> <p>4 forwarded it on to marketing, it</p> <p>5 appears.</p> <p>6 BY MS. RUANE:</p> <p>7 Q. It was provided by the</p> <p>8 national account managers, right?</p> <p>9 A. Yes, yes. I didn't write</p> <p>10 the document.</p> <p>11 So when you're asking me</p> <p>12 specifics around each of these plans, I</p> <p>13 don't have the context to answer the</p> <p>14 question.</p> <p>15 Q. But at least what we know</p> <p>16 from Exhibit-13 is that the national</p> <p>17 account managers were reporting</p> <p>18 conversations regarding questions on use</p> <p>19 and abuse of opioids?</p> <p>20 MS. HILLYER: Objection.</p> <p>21 Calls for speculation.</p> <p>22 BY MS. RUANE:</p> <p>23 Q. I mean, would you agree? We</p> <p>24 just looked at this.</p>
<p style="text-align: right;">Page 191</p> <p>1 A. Based on this, I would also</p> <p>2 agree that there are other opioids on the</p> <p>3 market. It was a general opioids</p> <p>4 statement. Because it's a Schedule II,</p> <p>5 it's logical to have that -- that's why</p> <p>6 it's a Schedule II.</p> <p>7 Q. Okay. I'm going to hand you</p> <p>8 what's been marked as Exhibit-14.</p> <p>9 - - -</p> <p>10 (Whereupon, Teva-Bearer</p> <p>11 Exhibit-14, TEVA_MDL_A_04481825,</p> <p>12 was marked for identification.)</p> <p>13 - - -</p> <p>14 MS. RUANE: It's</p> <p>15 TEVA_MDL_A_04481825.</p> <p>16 BY MS. RUANE:</p> <p>17 Q. This is an e-mail from</p> <p>18 Robert Host to you.</p> <p>19 Do you see that?</p> <p>20 A. Yes.</p> <p>21 Q. He references a Dr. Guarino,</p> <p>22 who is a physician in St. Louis who just</p> <p>23 presented a poster study at a recent pain</p> <p>24 meeting on nonmalignant pain for Actiq.</p>	<p style="text-align: right;">Page 192</p> <p>1 Do you see that?</p> <p>2 A. I see that.</p> <p>3 Q. Nonmalignant pain is pain</p> <p>4 that is not related to cancer, correct?</p> <p>5 A. That's correct.</p> <p>6 Q. Speaking with Amy Jordheim,</p> <p>7 the MDM.</p> <p>8 Who is Amy Jordheim? What</p> <p>9 does MDM refer to?</p> <p>10 A. I don't remember the acronym</p> <p>11 now, but it's basically an MSL. I just</p> <p>12 don't know what they --</p> <p>13 Q. Now I have to ask what an</p> <p>14 MSL is?</p> <p>15 A. Medical science liaison. So</p> <p>16 they fall under the medical side. They</p> <p>17 deal with KOLs, thought leaders. They're</p> <p>18 medical, not sales.</p> <p>19 Q. Got it.</p> <p>20 So she thinks, He --</p> <p>21 referring to Dr. Guarino -- would be</p> <p>22 an -- would be excellent to speak to</p> <p>23 health plans. And the fact that he has</p> <p>24 actually completed a study for Actiq in</p>

1 nonmalignant pain might be beneficial for
2 other speakers to hear him at our meeting
3 in January.

4 Did I read that correctly?

5 A. Yes, you did.

6 Q. Okay. So you were aware of
7 the use of Actiq by speakers who are
8 physicians? We've spoken about that
9 before, right?

10 A. Correct.

11 Q. Would Dr. Guarino be the
12 type that we talked about before as a key
13 opinion leader?

14 MS. HILLYER: Objection to
15 the form.

16 THE WITNESS: I don't know
17 this.

18 BY MS. RUANE:

19 Q. Because he was published on
20 the use of Actiq in something other
21 than -- in something beyond breakthrough
22 cancer pain, it was thought he might be
23 beneficial for other speakers to hear?
24

MS. HILLYER: Objection.

1 Calls for speculation.

2 THE WITNESS: I don't know.

3 BY MS. RUANE:

4 Q. I mean, I'm just reading
5 from what you wrote here.

6 Because he's actually
7 completed a study for Actiq in
8 nonmalignant pain, it might be beneficial
9 for other speakers to hear him at our
10 meeting in January.

11 Do you see that?

12 MS. HILLYER: Objection to
13 form. She didn't write this.

14 BY MS. RUANE:

15 Q. Oh, I see. You received it.
16 My apologies.

17 Robert wrote to you --

18 A. Yes.

19 Q. -- indicating that that
20 might be beneficial, correct?

21 A. Yes.

22 Q. What meeting in January is
23 Robb referring to, if you know?

24 A. I don't recall.

1 Q. I'll tell you, the subject
2 up above indicates, Dr. Guarino for Actiq
3 managed care training.

4 A. Oh, yeah, it does say that.

5 Q. So would that have been a
6 meeting for managed care training?

7 MS. HILLYER: Objection.

8 Calls for speculation.

9 THE WITNESS: I don't know.

10 BY MS. RUANE:

11 Q. Is it reasonable to assume,
12 since the subject is Dr. Guarino for
13 Actiq managed care training, that the
14 meeting that's discussed would be a
15 managed care training meeting?

16 MS. HILLYER: Objection.

17 Calls for speculation.

18 THE WITNESS: That's what it
19 states.

20 BY MS. RUANE:

21 Q. Do you know whether -- well,
22 strike that.

23 Who is Robert Host?

24 A. A national account manager.

1 Q. And at this time, you were
2 also a national account manager?

3 A. Yes, I believe so, based on
4 the date. Yes.

5 Q. Did you have a management
6 role over Robert Host?

7 A. No, I really don't recall.

8 But they're asking me to
9 speak to marketing. So there was a point
10 where I was in management and still had a
11 home office, sort of liaison
12 responsibilities.

13 But that's perhaps why I
14 received this. That's a speculation. So
15 I don't know for sure.

16 Q. And when you say they're
17 asking you to speak to marketing, you're
18 referring to his request that you check
19 with Terry --

20 A. Yes.

21 Q. Okay.

22 Is this a suggestion from
23 Robert Host that Guarino should be
24 utilized to promote the off-label use of

<p style="text-align: right;">Page 197</p> <p>1 Actiq?</p> <p>2 MS. HILLYER: Objection to</p> <p>3 form.</p> <p>4 THE WITNESS: I can't -- I</p> <p>5 can't speculate as to what</p> <p>6 Robert's intention was.</p> <p>7 BY MS. RUANE:</p> <p>8 Q. But you do agree that the</p> <p>9 study he completed would be for off-label</p> <p>10 use of Actiq, correct?</p> <p>11 A. It states that he did a</p> <p>12 study on nonmalignant pain.</p> <p>13 We often were requested to</p> <p>14 bring in speakers, as I mentioned, to</p> <p>15 educate the plan. If the plan wanted to</p> <p>16 understand why the prescribers are</p> <p>17 prescribing Actiq, a request such as this</p> <p>18 could come in, and we would, if a --</p> <p>19 particularly if they've published</p> <p>20 something or have done a study, there's</p> <p>21 much more credibility, if the plan --</p> <p>22 these are clinical pharmacists.</p> <p>23 They may have a need to</p> <p>24 understand the data associated with</p>	<p style="text-align: right;">Page 198</p> <p>1 nonmalignant pain and Actiq. So it's</p> <p>2 very reasonable that you would have</p> <p>3 someone that has done a study to give</p> <p>4 that presentation --</p> <p>5 Q. And the data --</p> <p>6 A. -- upon request.</p> <p>7 Q. And the data associated with</p> <p>8 nonmalignant pain, it would be data</p> <p>9 associated with off-label use of Actiq,</p> <p>10 correct?</p> <p>11 A. Clinical studies can be done</p> <p>12 for any reason.</p> <p>13 But based on what I -- a</p> <p>14 physician makes a determination on how</p> <p>15 they want to study the product. So based</p> <p>16 on what I'm reading here, this physician,</p> <p>17 who I don't know, had a poster which</p> <p>18 suggests that he did a clinical</p> <p>19 presentation -- a clinical trial of some</p> <p>20 sort on nonmalignant pain, which is,</p> <p>21 again, outside the current -- outside</p> <p>22 that current label.</p> <p>23 Q. Yes, outside the indication,</p> <p>24 so off label, correct?</p>
<p style="text-align: right;">Page 199</p> <p>1 A. It's not in the current</p> <p>2 indication, yes.</p> <p>3 Q. And I just want to be sure</p> <p>4 we're on the same page.</p> <p>5 If it's outside the current</p> <p>6 indication -- inside the current</p> <p>7 indication is on label?</p> <p>8 A. Yes.</p> <p>9 Q. Outside the current</p> <p>10 indication is off label, right?</p> <p>11 A. That's correct, yes.</p> <p>12 Q. Okay.</p> <p>13 THE WITNESS: We're finished</p> <p>14 with this?</p> <p>15 MS. RUANE: Let's take a</p> <p>16 quick --</p> <p>17 MS. HILLYER: It's almost an</p> <p>18 hour. We're at 58.</p> <p>19 MS. RUANE: That's perfect.</p> <p>20 Let's do lunch.</p> <p>21 VIDEO TECHNICIAN: Going off</p> <p>22 the record. 12:45 p.m.</p> <p>23 - - -</p> <p>24 (Whereupon, a luncheon</p>	<p style="text-align: right;">Page 200</p> <p>1 recess was taken.)</p> <p>2 - - -</p> <p>3 VIDEO TECHNICIAN: Back on</p> <p>4 record at 1:28 p.m.</p> <p>5 BY MS. RUANE:</p> <p>6 Q. We're back on the record</p> <p>7 after a lunch break.</p> <p>8 Do you understand you're</p> <p>9 still under oath?</p> <p>10 A. Yes.</p> <p>11 Q. Let me ask you, what</p> <p>12 promotional activities did you perform</p> <p>13 with regard to managed care for Actiq?</p> <p>14 A. In engaging with the payers,</p> <p>15 we would have approved materials. In</p> <p>16 fact, I think we often used sales</p> <p>17 materials because we didn't have a</p> <p>18 managed care marker, like I am</p> <p>19 presenting -- putting together specifics.</p> <p>20 And there was a presentation, as I</p> <p>21 recall.</p> <p>22 Q. And I apologize, I'm going</p> <p>23 to repeat some of that to make sure I</p> <p>24 heard you okay. All right?</p>

1 So one of the things you
2 mentioned were actually using the sales
3 materials that the sales force used?
4 A. We may have. There wasn't a
5 managed care marketing department back in
6 those days, which is what I do now.
7 Therefore, managed care-specific pieces
8 were somewhat limited.
9 Q. Because the managed care
10 team was kind of selling to the managed
11 care entities, while the sales team was
12 out with providers, correct?
13 MS. HILLYER: Objection to
14 form.
15 THE WITNESS: Managed
16 care -- the account managers would
17 present to payers if there was an
18 approved document, which, of
19 course, the sales force had
20 approved documents.
21 It's my recollection that,
22 in certain situations, we would
23 use promotional materials that
24 were approved for HCPs in general.

1 A. No.
2 Q. What promotional -- well,
3 strike that.
4 Before I ask, are there any
5 other promotional activities, as it
6 relates to Actiq, that you can recall?
7 A. With which audience?
8 Q. With the managed care
9 entities.
10 A. Not that I can recall.
11 Q. Were there other audiences
12 that you were involved in providing
13 promotional activities with regard to
14 Actiq on?
15 A. Not that I recall.
16 Q. What promotional activities
17 did you perform with regard to managed
18 care for Fentora?
19 A. Similar -- similarly, there
20 was a managed care presentation from a
21 promotional -- that would have to go
22 through our medical/legal, you know.
23 I believe when we launched
24 Fentora, I was transitioning to the other

1 BY MS. RUANE:
2 Q. And what promotional -- do
3 you remember the names or types of
4 promotional materials?
5 A. Honestly, I do not.
6 Q. You also mentioned a
7 presentation?
8 A. I believe there was a
9 presentation. I know we were -- I think
10 there was a point where we were asking
11 for input around promotional
12 presentation. Because the audience is
13 different with payers, oftentimes the
14 information may be different.
15 I honestly don't recall
16 presenting it, if it was, in fact,
17 approved.
18 Q. And would that have been
19 kind of -- is your memory of it a slide
20 deck-type presentation?
21 A. It would be, yes.
22 Q. Do you have a memory of the
23 name that that type of promotional
24 presentation was given?

1 position. So, again, I don't recall how
2 much interfacing, customer-facing, with
3 Fentora, I personally had.
4 Q. Okay. And so that managed
5 care presentation would be a slide deck
6 as well?
7 A. Yes.
8 Q. Were there sales materials
9 used in the promotion of Fentora to
10 managed care entities?
11 A. I don't -- I don't recall.
12 Unlikely.
13 Q. Was that because at that
14 point the managed care department had its
15 own marketing?
16 A. Yes. So we had
17 payer-specific information.
18 Q. So the payer-specific
19 managed care marketing information for
20 Fentora would have been derived in the
21 managed care -- created within the
22 managed care system?
23 A. Correct. No. Created in
24 the managed care system?

1 Q. On the managed care team.
2 Somebody in the -- was there a marketing
3 person within the managed care team?
4 A. No -- well, until they moved
5 toward that. But at that point, if
6 memory serves, typically, the -- there
7 was a marketing brand team member who had
8 responsibility for the payer piece to it.
9 Q. Got it.
10 And do you recall who the
11 marketing brand team payer -- strike
12 that. Let me start over.
13 Do you recall who the
14 marketing brand team member who was
15 assigned to managed care was?
16 A. I believe it was Matt
17 Falker.
18 Q. How do you spell that last
19 name?
20 A. F, as in Frank, A-L, as in
21 live, K-E-R.
22 Q. Did you -- backing up.
23 Did you have a hand in the
24 creation of the promotional materials

1 used for Actiq?
2 A. No.
3 Q. Did you have a hand in the
4 creation of the promotional materials
5 used for Fentora?
6 MS. HILLYER: Objection.
7 THE WITNESS: For the payer?
8 BY MS. RUANE:
9 Q. Payer, yes.
10 A. Yes.
11 Could you define "hand,"
12 though? What do you mean?
13 Q. Did you provide content or
14 comments?
15 A. Comments.
16 Q. And those promotional
17 materials would be presented to managed
18 care entities and discussed with managed
19 care entities, correct?
20 A. Yes. Promotional materials
21 are presented to payers, managed care.
22 MS. RUANE: I'm going to
23 hand you what's been marked as
24 Exhibit-15.

1 - - -
2 (Whereupon, Teva-Bearer
3 Exhibit-15,
4 TEVA_MDL_A_09457158-159, was
5 marked for identification.)
6 - - -
7 MS. RUANE: The document
8 number is TEVA_MDL_A_09457158.
9 BY MS. RUANE:
10 Q. This was an e-mail to you.
11 And the subject is, Fentora MCO slides.
12 Do you see that?
13 A. Yes, I do.
14 Q. What is MCO?
15 A. Managed care organization.
16 Q. So would these be Fentora
17 slides for the managed care entities?
18 A. I'm going to look at it, but
19 based on the -- yes.
20 MS. HILLYER: Take your
21 time.
22 You've got two files
23 attached, it looks like, but only
24 one native Bates file attachment.

1 MS. RUANE: Let's see.
2 MS. HILLYER: I have these
3 two here, right?
4 MS. RUANE: Right. Let's
5 look at this.
6 MS. HILLYER: Are they all
7 part of one Bates?
8 MS. RUANE: They are all --
9 the Bates numbers are in order.
10 MS. HILLYER: Right. I have
11 the e-mail and one native file
12 attachment. So it looks like I
13 have two native file attachments.
14 MS. RUANE: I see what
15 you're saying. The second native
16 file attachment, Bates order-wise,
17 we go from 19457159 to 09457160.
18 MS. HILLYER: I don't have
19 60 here.
20 MS. RUANE: If you go -- do
21 you not have that page?
22 MS. HILLYER: Yes. That's
23 why I wanted to make sure. I
24 don't think I do.

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<p>1 MS. RUANE: That's a 2 printing issue on our end. 3 MS. HILLYER: All right. So 4 we're going to make it -- I don't 5 know if this copy does, then, 6 either. I just want to make sure 7 it's all -- that we keep track of 8 everything. 9 MS. RUANE: No, I appreciate 10 it. And I can explain it for the 11 record as well and get you that 12 native page. 13 MS. HILLYER: She also 14 doesn't have 60. 15 MS. RUANE: Then let me 16 explain for the record what it is, 17 just so that when we're looking 18 back later. 19 Thanks for clarifying that, 20 Becca. 21 BY MS. RUANE: 22 Q. So what you have before you 23 is Exhibit-18. And there is the native 24 page for the document entitled, Chronic</p>	<p>1 Pain, the Breakthrough Pain Component, 2 09457159. 3 The Bates number for the 4 managed care presentation is 09451760. 5 MS. HILLYER: That's the 6 draft for review? 7 MS. RUANE: The draft for 8 review. That's correct. 9 BY MS. RUANE: 10 Q. So let me ask you -- 11 MS. HILLYER: Sorry, I don't 12 mean to be picky. But the e-mail 13 only has one attachment, as far as 14 I can tell. 15 MS. RUANE: And that's 16 where -- 17 MS. HILLYER: So I just want 18 to make sure these really belong 19 together. 20 MS. RUANE: I understand. I 21 understand the concern. 22 All I can tell you is -- the 23 managed care speaker deck -- I 24 mean, we can go -- the thing that</p>
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<p>1 I'll say about it is if you look 2 at the 7158, and then chronic pain 3 is 7159, managed care is -- 4 MS. HILLYER: Not referenced 5 on the title. 6 MS. RUANE: Okay. All 7 right. Let's do this. Take out 8 managed care. I don't want to 9 confuse it. We'll deal with that 10 separately. 11 THE WITNESS: Okay. 12 MS. HILLYER: Okay. 13 MS. RUANE: All right. 14 MS. HILLYER: So what we 15 have here that says, Chronic Pain, 16 the Breakthrough Pain Component -- 17 MS. RUANE: Yes. 18 MS. HILLYER: -- that, 19 you're saying, is what is referred 20 to as attachment, Managed Care 21 Speaker Deck Version 2.1 -- 22 MS. RUANE: What I actually 23 think is the speaker deck includes 24 both of them, but I understand</p>	<p>1 that it looks like there's one 2 attachment. I think it's a 3 PowerPoint. I don't understand 4 why there would be two native 5 images, but they line up in order. 6 MS. HILLYER: But what are 7 the Bates -- are there two Bates? 8 MS. RUANE: There's two 9 Bates. 10 MS. HILLYER: So it could 11 just be a different native file 12 than what was attached. 13 MS. RUANE: Correct. So 14 that's why, let's just leave it on 15 its own and we can deal with it -- 16 MS. HILLYER: So Chronic 17 Pain, the Breakthrough Pain 18 Component is TEVA_MDL_A_09457159. 19 MS. RUANE: Yes. Correct. 20 MS. HILLYER: So what we 21 have as Exhibit-15, then, is 7158 22 through 7159? 23 MS. RUANE: Yes. 24 MS. HILLYER: We're going to</p>

1 set this one aside. We're going
 2 to focus this on the side and
 3 focus on those two, the cover
 4 e-mail and the attachment.
 5 THE WITNESS: Got it.
 6 BY MS. RUANE:
 7 Q. So this is a managed care
 8 speaker deck from 2007 regarding Fentora,
 9 correct?
 10 A. That's what it says on the
 11 e-mail.
 12 Q. You have no reason to
 13 disagree or dispute that, correct?
 14 A. I -- there's nothing in this
 15 document that says anything about managed
 16 care.
 17 So I'm -- I have no way of
 18 knowing if this e-mail is in conjunction
 19 with this deck.
 20 Q. And I'll tell you the way
 21 that we, as attorneys, discern that is
 22 the number assigned to it, the last two
 23 digits there, 58, on the e-mail. And on
 24 that chronic pain document, the last two

1 digits are 59.
 2 So that's how we discern
 3 that that's the attachment that goes with
 4 it within our system.
 5 But let me just ask you a
 6 couple of questions about it.
 7 A. Sure.
 8 MS. HILLYER: And sorry,
 9 again, to be picky, but the
 10 numbers on the deck, you wrote
 11 those in hand, right?
 12 MS. RUANE: Oh, yeah, I'm
 13 sorry. On the page numbers, yes.
 14 MS. HILLYER: Yes.
 15 BY MS. RUANE:
 16 Q. I should have clarified.
 17 So because this document
 18 doesn't have page numbers, just for ease
 19 of reference, I added page numbers on the
 20 bottom so that we could follow along.
 21 So if you turn to Page 5 --
 22 A. I'm tracking with you now.
 23 Q. -- you'll see there, Chronic
 24 pain overview?

1 A. Yes.
 2 Q. And below that, a bullet
 3 point for, Pain is pain, correct?
 4 A. I see that.
 5 Q. And that -- below that, it
 6 says, CA and nonCA patients.
 7 That refers to cancer and
 8 noncancer patients, correct?
 9 A. That's what it says.
 10 MS. HILLYER: Objection to
 11 form. Calls for speculation.
 12 BY MS. RUANE:
 13 Q. That's your understanding of
 14 the CA reference within the Fentora
 15 documents is cancer, correct?
 16 A. I don't know. It doesn't
 17 say cancer.
 18 Q. Do you understand CA --
 19 A. I do --
 20 Q. -- to be cancer?
 21 A. Oh, I've never seen -- I
 22 don't recall seeing this document before.
 23 Q. But you would agree that the
 24 CA and nonCA patients'-pathophysiology,

1 the same regardless of etiology or
 2 underlying disease, that that's
 3 referenced under pain is pain on
 4 Exhibit-15, correct?
 5 A. I see the reference, yes.
 6 Q. And this is a slide deck
 7 regarding Fentora, correct?
 8 MS. HILLYER: Objection to
 9 form.
 10 THE WITNESS: I'm just --
 11 okay. There's nothing in this
 12 deck, other than the fact that
 13 it's on the Fentora template, that
 14 I'm seeing that says Fentora.
 15 BY MS. RUANE:
 16 Q. There is the reference to
 17 FEBT, correct, in the bottom right-hand
 18 corner?
 19 A. That's what I just stated.
 20 Other than the template itself, as I go
 21 through this deck, this is -- it has many
 22 topics.
 23 Q. I'm sorry, this is one of
 24 those times where it's -- I don't mean to

<p style="text-align: right;">Page 217</p> <p>1 be misstating what you're saying, I'm</p> <p>2 just trying to make sure I understand it</p> <p>3 and hear you.</p> <p>4 A. Ask the question again.</p> <p>5 Q. So this is a Fentora</p> <p>6 template, right?</p> <p>7 A. This is a Fentora template,</p> <p>8 yes.</p> <p>9 Q. And it's a slide deck that</p> <p>10 was provided to you in 2007, correct?</p> <p>11 A. It was e-mailed to me.</p> <p>12 Q. Yes.</p> <p>13 It was provided to you via</p> <p>14 e-mail, correct?</p> <p>15 A. It was provided to me, yes.</p> <p>16 I had a copy of it.</p> <p>17 Q. And it references "pain is</p> <p>18 pain"?</p> <p>19 A. In this deck, it does.</p> <p>20 Q. And right below that, it</p> <p>21 references cancer and noncancer patients,</p> <p>22 correct?</p> <p>23 A. Correct.</p> <p>24 Q. Okay. And that would be</p>	<p style="text-align: right;">Page 218</p> <p>1 beyond the indication for Fentora,</p> <p>2 correct?</p> <p>3 A. This is for speakers. This</p> <p>4 is not for promotional use by an account</p> <p>5 manager. That's what it states.</p> <p>6 Q. Sorry. Go ahead.</p> <p>7 My question was a little</p> <p>8 different.</p> <p>9 You agree that is beyond the</p> <p>10 indication for Fentora, correct?</p> <p>11 A. For Fentora, yes.</p> <p>12 Q. And so Teva would provide</p> <p>13 speakers with these slide decks to use</p> <p>14 when speaking with managed care entities?</p> <p>15 MS. HILLYER: Objection.</p> <p>16 Calls for speculation.</p> <p>17 THE WITNESS: I don't know.</p> <p>18 BY MS. RUANE:</p> <p>19 Q. Well, it's a speaker deck --</p> <p>20 you just clarified it's a speaker deck --</p> <p>21 A. It is a speaker deck.</p> <p>22 Q. -- for a speaker, correct?</p> <p>23 MS. HILLYER: Objection to</p> <p>24 form.</p>
<p style="text-align: right;">Page 219</p> <p>1 BY MS. RUANE:</p> <p>2 Q. For a physician?</p> <p>3 MS. HILLYER: Same</p> <p>4 objection.</p> <p>5 THE WITNESS: It says</p> <p>6 nothing here stating that. The</p> <p>7 only thing it says is -- I'm</p> <p>8 looking at the e-mail --</p> <p>9 and Darren Keese, I don't even</p> <p>10 know who that is.</p> <p>11 BY MS. RUANE:</p> <p>12 Q. I'll tell you what, let's do</p> <p>13 this. I'm going to mark as Exhibit-16,</p> <p>14 the managed care presentation draft for</p> <p>15 review.</p> <p>16 MS. HILLYER: We don't have</p> <p>17 a Bates?</p> <p>18 MS. RUANE:</p> <p>19 TEVA_MDL09451760. And I can get</p> <p>20 you a native page for that, I</p> <p>21 apologize it wasn't on it.</p> <p>22 - - -</p> <p>23 (Whereupon, Teva-Bearer</p> <p>24 Exhibit-16, TEVA_MDL09451760, was</p>	<p style="text-align: right;">Page 220</p> <p>1 marked for identification.)</p> <p>2 - - -</p> <p>3 BY MS. RUANE:</p> <p>4 Q. And the first page of this</p> <p>5 document indicates it's a managed care</p> <p>6 presentation draft for review, correct?</p> <p>7 A. Yes, that's what it says.</p> <p>8 Q. So this would be a</p> <p>9 presentation.</p> <p>10 It's on a Fentora template,</p> <p>11 right?</p> <p>12 A. Yes, it is.</p> <p>13 Q. Page 2 includes disclosures.</p> <p>14 So there would be -- it references, in</p> <p>15 the first bullet point, I'm an outside</p> <p>16 consultant retained by Cephalon, correct?</p> <p>17 A. Correct.</p> <p>18 Q. So this would be a document</p> <p>19 used by an outside consultant retained by</p> <p>20 Cephalon.</p> <p>21 And this presentation was</p> <p>22 going to include, based on Exhibit-3,</p> <p>23 discussion of off-label uses of Fentora,</p> <p>24 correct?</p>

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1 A. Second bullet, in a response
2 to an unsolicited request.
3 Q. I'm sorry, I meant to say
4 the third bullet.
5 A. That's what the third bullet
6 says.
7 Q. And that's a process that
8 you were familiar with in your role with
9 managed care, that physicians would be
10 retained and paid by the company to speak
11 on off-label uses of Fentora?
12 MS. HILLYER: Objection to
13 form.
14 THE WITNESS: Upon
15 unsolicited request.
16 BY MS. RUANE:
17 Q. So if there was an
18 unsolicited request by a managed care
19 entity, the next step would be for the
20 company to have an individual physician
21 retained by them go in to speak to the
22 managed care entity on topics, including
23 off-label use of Fentora?
24 A. If it was requested.

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1 Q. So that's a correct
2 statement?
3 A. If they requested broad use
4 of Fentora, a presentation on that, then
5 that would be -- that request would be
6 fulfilled.
7 Q. Fulfilled, okay.
8 So at those presentations,
9 would employees of the company, Cephalon
10 and then subsequently Teva, be present?
11 A. I don't recall who would be
12 present specifically, to be honest with
13 you.
14 Q. Do you have any reason to
15 think that the representative from the
16 company would not have attended those
17 presentations?
18 A. No.
19 Q. Okay.
20 A. Typically, it would be a
21 medical person.
22 Q. Typically --
23 A. As I recall.
24 Q. Sorry. Just to make sure I

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1 understand.
2 Typically a medical
3 person --
4 A. Accompanying --
5 Q. -- within the company would
6 attend?
7 A. Sorry. Accompanying a
8 speaker.
9 Q. Got it. Accompanying a
10 speaker?
11 A. Yes. Correct.
12 Q. I'm going to say it one last
13 time, just to be sure.
14 A. Please do.
15 Q. So in your memory it would
16 typically be an employee of the company
17 within the medical department who would
18 be accompanying the speaker to the
19 presentation?
20 A. That's what I recall, yes.
21 Q. Got it.
22 Have you seen these managed
23 care program slides before, this
24 Exhibit-16?

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1 A. It was e-mailed to me, so
2 the answer is yes. But I don't know --
3 again, I'm confused about -- pardon me.
4 MS. HILLYER: Just to be
5 clear, I don't know that this was
6 part of that e-mail.
7 THE WITNESS: In that case,
8 I don't know.
9 BY MS. RUANE:
10 Q. I'll figure that out on my
11 end.
12 If it was e-mailed to you --
13 well, strike that.
14 Let me ask it this way: Do
15 you have a memory of reviewing managed
16 care presentations?
17 MS. HILLYER: For Actiq and
18 Fentora?
19 MS. RUANE: For Fentora.
20 THE WITNESS: For Fentora?
21 For promotion?
22 MS. HILLYER: For promotion,
23 she said.
24 THE WITNESS: For promotion.

1 BY MS. RUANE:
 2 Q. Let's ask it both ways.
 3 Do you have a memory of
 4 reviewing managed care presentations for
 5 promotion of Fentora?
 6 A. Yes.
 7 Q. Do you have a memory of
 8 reviewing managed care presentations for
 9 speakers?
 10 A. I don't -- I don't remember,
 11 honestly.
 12 Q. Exhibit-16 that's before
 13 you, did you have any role or
 14 responsibility in reviewing or preparing
 15 this document?
 16 A. Are we talking about this
 17 one?
 18 Q. Yes.
 19 A. Okay. Is there a date
 20 associated with this, by the way?
 21 Because that will help me give you --
 22 Q. I mean, it would have been
 23 in the 2007 time frame, as best I can
 24 tell. There's citations in here to

1 correct?
 2 A. A managed care employee
 3 would present? You mean a Cephalon
 4 employee under managed care would
 5 present?
 6 Q. Yes. Yes.
 7 A. We typically would name them
 8 managed care presentation for --
 9 presentation for managed care
 10 decision-makers, that was the common --
 11 Q. Managed care
 12 decision-makers?
 13 A. Yes, that was -- I know of
 14 recently that's the way they have been
 15 done.
 16 MS. HILLYER: The page
 17 numbers on that last one you guys
 18 put on, too, right?
 19 MS. RUANE: Yes, correct.
 20 I'm going to hand you
 21 Exhibit-17.
 22 - - -
 23 (Whereupon, Teva-Bearer
 24 Exhibit-17,

1 2006 --
 2 A. No, I was not involved with
 3 this. This, again, is the -- for a
 4 physician speaker. I did not -- and my
 5 role was not to develop speaker
 6 program -- speaker slides for speakers.
 7 Q. How could we tell -- how
 8 could we tell when a managed care
 9 presentation is for promotion and
 10 something that the managed care team
 11 would present? Like, is there a
 12 distinction made in the way they're
 13 named?
 14 A. There should have been. If
 15 there wasn't, I don't recall. That's why
 16 I previously was asking you about the
 17 presentations. This is not something
 18 that an account manager would present.
 19 This stack.
 20 Q. Okay. There's a separate
 21 version -- well, there's a separate type
 22 of presentation that went through the
 23 promotion committee to be approved that a
 24 managed care employee would present,

1 TEVA_MDL_A_04420139-141, was
 2 marked for identification.)
 3 - - -
 4 BY MS. RUANE:
 5 Q. You were involved in the
 6 hotline that was available to healthcare
 7 providers attempting to obtain coverage
 8 for products like Actiq and Fentora,
 9 correct?
 10 A. When you say "involved,"
 11 this was work for the entire Cephalon,
 12 the hotline.
 13 Q. The hotline, as it relates
 14 to you --
 15 A. Yes.
 16 Q. -- we talked earlier about
 17 the fact that you were kind of the
 18 subject matter expert on managed care
 19 issues, right?
 20 A. What time frame are you
 21 talking about?
 22 Q. Well, let's talk about this
 23 e-mail first. This was in 2005.
 24 That would have been part of

1 your role, correct?
2 A. No. At this point, I was an
3 account manager in the field.
4 Q. And you were copied on --
5 well, I guess the e-mail chain includes
6 you?
7 A. Yes.
8 Q. And is referencing some
9 questions about the hotline for national
10 account managers.
11 Do you see that?
12 MS. HILLYER: Give her a
13 minute to look it over.
14 THE WITNESS: Okay. Ask
15 your question again.
16 BY MS. RUANE:
17 Q. Okay. The hotline possesses
18 tools needed, such as LMN templates and
19 other documents that are a part of
20 creating prior authorization or appeals
21 documentation, right?
22 Is that the way -- I mean, I
23 can --
24 MS. HILLYER: Objection.

1 A. It's about the process.
2 Q. And sometimes --
3 MS. RUANE: I'm going to
4 hand you what's been marked as
5 Exhibit-18.
6 - - -
7 (Whereupon, Teva-Bearer
8 Exhibit-18,
9 TEVA_MDL_A_04848188-191, was
10 marked for identification.)
11 - - -
12 MS. RUANE: For the record,
13 this is TEVA_MDL_A_04848188.
14 BY MS. RUANE:
15 Q. I'll give you a second to
16 review it.
17 MS. HILLYER: It's tiny, the
18 print.
19 THE WITNESS: Okay. Maybe
20 with your question I'll need to
21 read it again, but go ahead.
22 BY MS. RUANE:
23 Q. The e-mail chain starts off
24 with an e-mail from -- on Page 89, with

1 BY MS. RUANE:
2 Q. -- ask it more generally if
3 it's easier and faster, okay?
4 One of the things that would
5 happen with the hotline was providers
6 could call the hotline and the hotline
7 had tools, like letters of medical
8 necessity templates, correct?
9 A. Correct.
10 Q. There may be other documents
11 that help with prior authorization or an
12 appeals documentation issue, right?
13 A. Correct.
14 Q. And so what the hotline was
15 intended to do, at least in part, was
16 help patients secure coverage for the
17 products carried by Cephalon and then
18 Teva, right?
19 A. It was -- the intent of the
20 hotline was to help the physician's
21 office and/or the patient navigate the
22 process to submit prior authorizations
23 for access.
24 Q. Okay.

1 an e-mail from Alec Burlakoff?
2 A. Yes.
3 Q. And he's describing a
4 situation where a call was made to the
5 hotline.
6 And the first question asked
7 was, Does this patient have cancer?
8 Do you see that?
9 A. Yes, I do.
10 Q. And the office staff said
11 no.
12 Do you see that?
13 A. Yes.
14 Q. And the person from the
15 hotline says, Sorry, we cannot help you,
16 have a nice day, and hung up.
17 Do you see that?
18 A. Yes, I see that.
19 Q. The discussion is, it's
20 described as a mishap by Alec, correct?
21 He says, I truly believe
22 these mishaps are partly the reason for
23 the lack of hotline usage. It is a
24 shame.

1 A. That's his opinion.
 2 Q. The e-mail is then forwarded
 3 to you --
 4 A. Yep.
 5 Q. -- from Randy Spokane. And
 6 you forward it on and indicate, I am
 7 concerned -- this is at the top of 89.
 8 I am concerned about this
 9 incident and the possibility of these
 10 situations arising. Fortunately, the
 11 representative at the physician office --
 12 was at the physician office and was able
 13 to address the miscommunication as it
 14 occurred.
 15 Do you see that?
 16 A. I see that.
 17 Q. And then there's some
 18 discussion of different possibilities for
 19 why that might have happened that way.
 20 But, ultimately, at the top
 21 of Page 88, Randy clarifies the initial
 22 reason for the call was for a noncancer
 23 patient.
 24 Do you see that?

1 Macilwain on the first page, patient
 2 assistance program. Our patient
 3 assistance program is different than the
 4 hotline, although they facilitated the
 5 call.
 6 And the patient assistance
 7 program was only for patients with
 8 breakthrough cancer pain.
 9 Q. But you were concerned about
 10 the possibility of patients who don't
 11 have cancer not being able to move
 12 forward through the hotline and obtain
 13 additional information in order to seek
 14 reimbursement, correct?
 15 A. No. The issue would be,
 16 based on my recollection, the training of
 17 the customer service hotline.
 18 The first question you don't
 19 have to -- you would not necessarily have
 20 to -- you wouldn't ask, is the diagnosis.
 21 The hotline is providing reimbursement
 22 support services, to include prior auth
 23 forms, although we talked about, not
 24 based on diagnosis.

1 A. Yes.
 2 Q. So this was a call for a
 3 patient who would be receiving Actiq for
 4 an off-label purpose, correct?
 5 A. That's what that -- that's
 6 what -- I'm sorry. That's what Randy
 7 states.
 8 Q. And so the hotline was
 9 correct to ask whether the patient had
 10 cancer, because that's the indication for
 11 the drug, correct?
 12 MS. HILLYER: Objection to
 13 form.
 14 THE WITNESS: That is not
 15 correct.
 16 BY MS. RUANE:
 17 Q. The question, does this
 18 patient have cancer, is intended to
 19 determine whether this is a patient
 20 within the indication for the label of
 21 the drug, correct?
 22 A. No.
 23 Q. Why not?
 24 A. I can't -- if you read Lynn

1 Q. So it would be your
 2 expectation, and the reason you were
 3 following up was so that the hotline was
 4 not seeking information that would
 5 determine whether a patient had cancer --
 6 MS. HILLYER: Objection to
 7 the form.
 8 BY MS. RUANE:
 9 Q. -- as the initial question
 10 on the call?
 11 A. The reason I was following
 12 up is if this was a patient assistance
 13 program, it may be appropriate to ask
 14 that, because the patient wouldn't
 15 qualify, you know, for patient
 16 assistance.
 17 And there was a warm
 18 transfer, as I recall, for the patient
 19 assistance program, which was sort of
 20 there was a firewall between
 21 reimbursement hotline services and the
 22 patient assistance program, or otherwise
 23 referred to as PAP.
 24 Q. And if this wasn't a patient

1 assistance program call --

2 A. Yes.

3 Q. -- if this was just a call
4 for a patient of any other sort, your
5 expectation is that whether they were a
6 cancer patient would not be relevant to
7 whether the hotline was providing
8 services to them for reimbursement?

9 A. Correct.

10 Q. Because the purpose of the
11 hotline was to provide reimbursement
12 services, even if the patient did not
13 have cancer, correct?

14 A. It was not based on
15 diagnosis. There may have been prior
16 auth criteria beyond the diagnosis, of
17 which, again, navigating the process for
18 coverage was relatively foreign to a lot
19 of these offices, and that was the intent
20 of the service.

21 It was up to the physician
22 to determine what was an appropriate
23 patient and go through that process.

24 Q. But the intent of the

1 service, to the extent possible, was to
2 provide reimbursement services for
3 uses -- for use of the product even if it
4 is beyond the indication on the label,
5 correct?

6 MS. HILLYER: Objection to
7 the form.

8 THE WITNESS: Why don't you
9 rephrase that for me so I can give
10 you a concise answer?

11 BY MS. RUANE:

12 Q. The purpose of the hotline
13 was to provide reimbursement services to
14 a provider, even if the particular
15 patient did not fall within the
16 indication on the label?

17 A. The diagnosis is not
18 included in a reimbursement support
19 service. It's just not. It's not a
20 screening based on your indication.

21 Q. So you would agree, then,
22 that the hotline was not screening based
23 on whether a patient was receiving
24 services on indication -- within the

1 indication or outside of the indication?

2 A. They would -- if they wanted
3 reimbursement support services, typically
4 the prior auth form would be sent to the
5 office staff. The office staff includes
6 relevant information, to include
7 diagnosis.

8 And the part of the -- part
9 of the reimbursement support service was
10 to help facilitate that process not
11 specific to diagnosis. There's lots of
12 information required on pre-A forms.

13 Q. Are you aware of the fact
14 that Burlakoff pled guilty for illegal
15 promotion of a product by your
16 competitor, Subsys?

17 MS. HILLYER: Objection.
18 Calls for speculation. Assumes
19 facts not in evidence.

20 BY MS. RUANE:

21 Q. Are you aware of that?

22 A. No.

23 Q. Do you know Alec Burlakoff?

24 A. No.

1 Q. When you received this
2 e-mail, you were -- and received Randy's
3 e-mail indicating the initial reason for
4 the call was for a noncancer patient, you
5 were aware of the fact that that would be
6 a patient, then, who was prescribed the
7 drug for off-label use, correct?

8 A. Correct.

9 Q. And you're aware of the fact
10 that for a while, at least, the hotlines
11 had at their disposal letters of medical
12 necessity as one of the tools to
13 facilitate reimbursements?

14 A. There was a period of time.
15 I don't recall how long it was, actually.

16 Q. The letters of medical
17 necessity included a range of conditions,
18 and you would agree some of those
19 conditions were off-label uses, correct?

20 A. As I recall. I don't have a
21 recollection of exactly what they were.

22 Q. We can get them out if we
23 need to.

24 A. Okay.

1 Q. But, for example, there
2 might be a letter of medical necessity
3 related to back pain?
4 MS. HILLYER: Objection.
5 Calls for speculation. She said
6 she doesn't remember the
7 specifics.
8 BY MS. RUANE:
9 Q. Do you have a memory of
10 that?
11 A. No.
12 Q. Okay. Actually, before I
13 bring up another exhibit, let me ask you,
14 those letters of medical necessity were
15 used, I know you don't remember exactly
16 when, it looks to me from 2008 to 2011.
17 Would that be consistent
18 with your memory, or do you know?
19 A. I don't know the dates.
20 Q. Okay. Do you know why the
21 letters of medical necessity program was
22 discontinued in 2011?
23 A. No.
24 Q. Did anyone ever talk to you

1 A. Yes.
2 Q. -- being supported, were
3 letters of medical necessity for the
4 within-indication use of Fentora still
5 available, even after the off-label
6 letters of medical necessity had been
7 discontinued?
8 A. I don't recall.
9 Q. Okay. Do you have any
10 reason to think that that didn't continue
11 to occur?
12 A. I find it interesting that
13 we would need a letter of medical
14 necessity if the patient was eligible for
15 the product.
16 The idea is if there's some
17 reason -- and if there was some reason
18 that they would, then there may be a
19 template to follow.
20 MS. RUANE: I'm going to
21 hand you what's been marked as
22 Exhibit-19. For the record, this
23 is TEVA_MDL_A_01204074 through
24 092.

1 about the reason for the discontinuation
2 of that program?
3 A. No, not -- no, I don't
4 recall having a conversation about it.
5 Q. Are letters of medical
6 necessity still used for on-label use of
7 the products?
8 MS. HILLYER: For Actiq and
9 Fentora?
10 THE WITNESS: For Actiq and
11 Fentora?
12 BY MS. RUANE:
13 Q. For Fentora.
14 MS. HILLYER: Objection to
15 form.
16 You can answer if you know.
17 But she's not in that role
18 anymore.
19 THE WITNESS: We don't
20 support Fentora.
21 BY MS. RUANE:
22 Q. A better question might be,
23 during the time that Fentora was on the
24 market --

1 - - -
2 (Whereupon, Teva-Bearer
3 Exhibit-19,
4 TEVA_MDL_A_01204074-092, was
5 marked for identification.)
6 - - -
7 BY MS. RUANE:
8 Q. This is a Vantrela strategic
9 brand plan.
10 And you were involved in the
11 strategy associated with the Vantrela
12 project -- product, correct?
13 A. As it related to market
14 access, yes.
15 Q. So within market access, one
16 of your jobs was to determine whether
17 managed care would pay for a product like
18 Vantrela?
19 A. Yes.
20 Q. Were you involved in the
21 creation of the strategic brand plan for
22 Vantrela?
23 A. The brand plan itself, no.
24 Q. What portion of the Vantrela

1 strategy would you have been involved in?
 2 A. Payer strategy.
 3 Q. Got it.
 4 And the payer strategy would
 5 be the strategy for, basically, building
 6 the case for payers to understand the
 7 benefit of providing coverage for a drug
 8 like Vantrela?
 9 A. Correct.
 10 Q. One of the things that is
 11 relevant in providing -- making the case
 12 to payers for why coverage for a product
 13 like Vantrela is important is
 14 establishing the need for abuse-deterrent
 15 technology in drugs, correct?
 16 MS. HILLYER: Objection to
 17 form.
 18 THE WITNESS: A treatment --
 19 I would say a treatment option for
 20 patients.
 21 BY MS. RUANE:
 22 Q. And so in the strategic
 23 brand plan that was created by Teva, on
 24 Page 4, Number 1, the first topic there

1 opioid abuse and misuse that's increased
 2 over the past decade and now poses a
 3 serious public health issue, is that
 4 something that you personally believe to
 5 be true?
 6 MS. HILLYER: Objection to
 7 form.
 8 THE WITNESS: I don't
 9 have -- I'm not going to offer my
 10 opinion.
 11 BY MS. RUANE:
 12 Q. Do you hold an opinion?
 13 MS. HILLYER: Objection to
 14 form. It calls for speculation.
 15 She's not an expert on this.
 16 BY MS. RUANE:
 17 Q. Ms. Bearer, I'm just asking
 18 you, do you have an opinion as to whether
 19 there's an opioid epidemic that's causing
 20 a public health crisis right now in our
 21 nation?
 22 MS. HILLYER: Objection to
 23 form.
 24 THE WITNESS: As it relates

1 on the executive summary is, Abuse and
 2 misuse of opioids.
 3 Do you see that?
 4 A. Sorry.
 5 Yes.
 6 Q. It talks about, The
 7 prevalence of prescription opioid abuse
 8 and misuse that has increased in the past
 9 decade and poses a serious public health
 10 issue.
 11 Do you see that?
 12 A. Yes.
 13 Q. Do you agree with that
 14 characterization?
 15 MS. HILLYER: Objection to
 16 form. And also lack of
 17 foundation. She testified that
 18 she didn't have anything to do
 19 with this document.
 20 BY MS. RUANE:
 21 Q. We can go on and look at
 22 some others that you did.
 23 I'm just asking you right
 24 now, as it relates to the prevalence of

1 to what you were asking me -- I
 2 mean, no.
 3 BY MS. RUANE:
 4 Q. You don't believe that to be
 5 true?
 6 A. I'm answering the question
 7 based on what you provided me here.
 8 There's no --
 9 Q. I just want to make sure I
 10 understand your answer.
 11 You don't believe that there
 12 is a serious public health issue that's
 13 posed by the prevalence of prescription
 14 opioid abuse and misuse in our nation
 15 over the past decade?
 16 MS. HILLYER: Objection to
 17 form.
 18 THE WITNESS: If you're
 19 asking -- sorry.
 20 There are statistics to
 21 suggest that there is an opioid
 22 epidemic. I don't have any -- I
 23 did not have anything to do with
 24 this document. So that was my

1 previous answer.
 2 BY MS. RUANE:
 3 Q. But you have seen the
 4 statistics related to the opioid epidemic
 5 and the societal cost associated with
 6 that?
 7 A. Yes.
 8 MS. HILLYER: Objection to
 9 form.
 10 THE WITNESS: Sorry.
 11 BY MS. RUANE:
 12 Q. Did you see those documents
 13 as you prepared part of the brand plan
 14 associated with managed care and
 15 Vantrela?
 16 A. It was part of the --
 17 MS. HILLYER: Sorry.
 18 Objection. What documents?
 19 THE WITNESS: Yeah, I mean,
 20 what --
 21 BY MS. RUANE:
 22 Q. The -- let's do this.
 23 - - -
 24 (Whereupon, Teva-Bearer

1 Exhibit-20,
 2 TEVA_MDL_A_09191592-593, with
 3 attachment, was marked for
 4 identification.)
 5 - - -
 6 MS. RUANE: I'm going to
 7 hand you what's been marked as
 8 Exhibit-20. For the record, this
 9 is TEVA_MDL_A_09191592.
 10 THE WITNESS: Are we
 11 finished with this one?
 12 MS. RUANE: For now.
 13 BY MS. RUANE:
 14 Q. This document includes a
 15 managed care overview for Vantrela on
 16 Page 248?
 17 A. Yep.
 18 Q. And this is a document that
 19 you --
 20 MS. HILLYER: You said 248?
 21 MS. RUANE: 248, yes.
 22 MS. HILLYER: Oh, sorry,
 23 hold on. 1592, 1593 -- these are
 24 not sequential. 191593, and then

1 I jump to 83248.
 2 MR. GASTEL: It's the
 3 attachments to previous e-mails.
 4 MS. HILLYER: But this
 5 e-mail has several attachments
 6 which aren't attached here.
 7 MS. RUANE: Let's do this --
 8 MS. HILLYER: And there's
 9 no -- the earlier e-mail doesn't
 10 appear to have any attachments.
 11 BY MS. RUANE:
 12 Q. Let me ask you this, and
 13 then we'll sort out where to go.
 14 The document, 248, the
 15 managed care overview --
 16 A. Got it.
 17 Q. -- is that a document that
 18 you created?
 19 A. Yes.
 20 Q. On Page 252 of that
 21 document -- and, again, this is a managed
 22 care overview to be provided as it
 23 relates to the Vantrela product, right?
 24 A. Correct.

1 Q. Okay. On 252, you identify
 2 the fact that the misuse, abuse and
 3 diversion of opioids is a major public
 4 health concern, correct?
 5 A. Yes. And they are all
 6 referenced.
 7 Q. And if you look at the
 8 bottom, your references are there?
 9 A. Correct.
 10 Q. And you identify the fact
 11 that one in twenty Americans over 12
 12 abused opioids in 2010, correct?
 13 A. Based on the reference,
 14 correct.
 15 Q. You also identify the fact
 16 that one in three drug-related emergency
 17 room visits were opioid related in 2011,
 18 correct?
 19 A. Yep.
 20 Q. And you cited 18,000
 21 overdose deaths in 2014, correct?
 22 A. Cited it.
 23 Q. You included it in there
 24 with the citation?

<p style="text-align: right;">Page 253</p> <p>1 A. Yes, I'm sorry. That's what</p> <p>2 I said. Sorry. Cited, yes.</p> <p>3 Q. Sorry. And you also</p> <p>4 identified a more than 300 percent</p> <p>5 increase in overdose deaths from 1999 to</p> <p>6 2014, correct?</p> <p>7 A. Correct.</p> <p>8 Q. And those are statistics</p> <p>9 that you identified and chose to put in</p> <p>10 the managed care overview for Vantrela,</p> <p>11 correct?</p> <p>12 A. Correct.</p> <p>13 Q. They were significant</p> <p>14 statistics to you?</p> <p>15 MS. HILLYER: Objection to</p> <p>16 form.</p> <p>17 THE WITNESS: That's an</p> <p>18 opinion. They were factual.</p> <p>19 BY MS. RUANE:</p> <p>20 Q. They're factual.</p> <p>21 And they're persuasive when</p> <p>22 explaining to a managed care entity why</p> <p>23 reimbursement for an abuse-deterrent</p> <p>24 technology would be appropriate, correct?</p>	<p style="text-align: right;">Page 254</p> <p>1 MS. HILLYER: Objection to</p> <p>2 the form. And calls for</p> <p>3 speculation.</p> <p>4 THE WITNESS: They are</p> <p>5 facts.</p> <p>6 BY MS. RUANE:</p> <p>7 Q. And they're facts you chose</p> <p>8 to put in here for a reason, right?</p> <p>9 A. They are facts. We are</p> <p>10 looking at an abuse-deterrent</p> <p>11 formulation, and these are facts</p> <p>12 associated with, perhaps, the unmet need.</p> <p>13 Q. With, I'm sorry?</p> <p>14 A. These are facts associated</p> <p>15 with that reference. That's what I'm</p> <p>16 saying.</p> <p>17 Q. They're facts associated</p> <p>18 with the opioid epidemic and opioid</p> <p>19 abuse, correct?</p> <p>20 A. The word we use is a misuse,</p> <p>21 abuse and diversion.</p> <p>22 Q. Okay. They are facts that</p> <p>23 are significant to explain to a managed</p> <p>24 care facility just how dire the opioid</p>
<p style="text-align: right;">Page 255</p> <p>1 use, abuse and diversion has become in</p> <p>2 America, correct?</p> <p>3 MS. HILLYER: Objection to</p> <p>4 form.</p> <p>5 THE WITNESS: They are facts</p> <p>6 associated with -- they are just</p> <p>7 facts relative to opioid abuse,</p> <p>8 diversion and misuse, which is on</p> <p>9 the next slide, I believe. Unless</p> <p>10 I'm going backwards.</p> <p>11 BY MS. RUANE:</p> <p>12 Q. On Page 255 -- sorry, it's</p> <p>13 because of the staples --</p> <p>14 A. I'm going in the wrong</p> <p>15 direction.</p> <p>16 Q. It says at the top, Opioid</p> <p>17 abuse poses a substantial economic</p> <p>18 burden.</p> <p>19 Do you see that?</p> <p>20 A. Uh-huh.</p> <p>21 Q. That's information -- you</p> <p>22 typed that in, right, as you created this</p> <p>23 document, correct?</p> <p>24 A. I created the document.</p>	<p style="text-align: right;">Page 256</p> <p>1 Q. And you chose to define it</p> <p>2 as, Opioid abuse posing a substantial</p> <p>3 economic burden, right?</p> <p>4 A. Economic, yes.</p> <p>5 Q. And you include the fact</p> <p>6 that there's, in the United States, in</p> <p>7 the year 2015 there's \$27.6 billion in</p> <p>8 healthcare costs, correct?</p> <p>9 A. Yes. And that's a -- yes.</p> <p>10 Q. You also included \$28.3</p> <p>11 billion in workplace costs?</p> <p>12 A. Yes.</p> <p>13 Q. And \$5.6 billion in criminal</p> <p>14 justice costs?</p> <p>15 A. That's correct.</p> <p>16 Q. For a total societal cost,</p> <p>17 in 2015 alone, of \$61.5 billion, correct?</p> <p>18 A. Correct.</p> <p>19 Q. My question for you is, who</p> <p>20 do you believe should pay for the \$61.5</p> <p>21 billion per year in total societal cost?</p> <p>22 MS. HILLYER: Objection to</p> <p>23 form.</p> <p>24 THE WITNESS: You're asking</p>

1 my opinion?
 2 BY MS. RUANE:
 3 Q. Yeah. I'm asking whether
 4 you believe that it's appropriate and
 5 fair for the companies that profited from
 6 the use, abuse and diversion of opioids
 7 to pay for the societal cost that America
 8 is now facing?
 9 MS. HILLYER: Objection to
 10 the form.
 11 THE WITNESS: I don't know.
 12 MS. HILLYER: And assumes
 13 facts not in evidence.
 14 BY MS. RUANE:
 15 Q. Is it your belief that
 16 American taxpayers should bear that cost?
 17 MS. HILLYER: Objection to
 18 form.
 19 THE WITNESS: I really don't
 20 know.
 21 BY MS. RUANE:
 22 Q. Between American taxpayers
 23 and the companies that profited from the
 24 sale of opioids, wouldn't you agree that

1 third-party -- well, strike that -- for
 2 managed care entities to know is that
 3 there's \$61.5 billion a year right now
 4 that American society is bearing as a
 5 result of the opioid epidemic.
 6 A. Yes.
 7 MS. HILLYER: Objection.
 8 BY MS. RUANE:
 9 Q. And because that's a
 10 decision -- or that's information that
 11 you found significant at the time of
 12 working on Vantrela, I'm wondering what
 13 your personal opinion is as to who bears
 14 the burden for that cost.
 15 MS. HILLYER: Objection to
 16 form. Mischaracterizes the
 17 document. Assumes facts not in
 18 evidence. And same objections I
 19 made before. And asked and
 20 answered repeatedly now. She's
 21 answered your question.
 22 BY MS. RUANE:
 23 Q. I won't -- you can answer it
 24 one more time. I won't ask it again.

1 the appropriate thing to do would be for
 2 those companies to forfeit those profits
 3 in order to address the societal costs
 4 that they have created?
 5 MS. HILLYER: Objection to
 6 form. And assumes facts not in
 7 evidence. And calls for a legal
 8 conclusion.
 9 BY MS. RUANE:
 10 Q. Wouldn't you agree, Ms.
 11 Bearer?
 12 MS. HILLYER: Same
 13 objections.
 14 THE WITNESS: I'm not an
 15 attorney. You're asking for me to
 16 provide you a response that
 17 implies a legal reference that --
 18 I'm sorry. I'm not an attorney.
 19 BY MS. RUANE:
 20 Q. And with all respect, I'm
 21 not asking for an opinion -- or a legal
 22 opinion right now.
 23 I'm -- I understand that you
 24 identified, as an important thing for

1 MS. HILLYER: Same
 2 objections.
 3 THE WITNESS: I'm not an
 4 attorney and, therefore, cannot
 5 provide an opinion as to -- to
 6 answer your question.
 7 MS. HILLYER: Sarah, do you
 8 want to separate these as
 9 documents, because they don't
 10 actually belong together? Or how
 11 do you want to --
 12 MR. GASTEL: They definitely
 13 belong together. There's just
 14 numerous attachments and they are
 15 all not --
 16 MS. HILLYER: So it's just
 17 missing the in-between attachments
 18 you're saying? I see. As long as
 19 we're clear on the record, that's
 20 fine.
 21 THE WITNESS: Are we
 22 finished with this?
 23 MS. HILLYER: That one goes
 24 before that.

1 THE WITNESS: So we're
2 finished with both of them, okay.
3 Sounds good.
4 MS. HILLYER: We've been
5 going about an hour. If you have
6 another quick document, we can do
7 it, but --
8 MS. RUANE: Let's take a
9 quick break.
10 VIDEO TECHNICIAN: Going off
11 the record. 2:25.
12 - - -
13 (Whereupon, a brief recess
14 was taken.)
15 - - -
16 VIDEO TECHNICIAN: Back on
17 record at 2:39 p m.
18 BY MS. RUANE:
19 Q. We're back on the record
20 after a short break.
21 You understand you're still
22 under oath?
23 A. I do.
24 Q. We're going to hand you

1 what's been marked as Exhibit-21.
2 - - -
3 (Whereupon, Teva-Bearer
4 Exhibit-21,
5 TEVA_MDL_A_09165564-565, with
6 attachment, was marked for
7 identification.)
8 - - -
9 BY MS. RUANE:
10 Q. And there's the e-mail
11 itself which, for the record, is
12 TEVA_MDL_A_0916564 to 65, and then the
13 attachment is included on the back there.
14 This is a managed care mag
15 article for opioids.
16 This is an e-mail chain that
17 includes you and Jeff Dierks, at least at
18 the top.
19 Do you see that?
20 A. I do.
21 Q. Who is Jeff Dierks?
22 A. He was the brand director at
23 the time for Fentora.
24 Q. You said brand director for

1 Fentora?
2 A. Yes.
3 Q. You wrote Jeff about the
4 article titled, The Societal and Economic
5 Burden of Chronic Pain and Opioid Abuse,
6 correct?
7 A. Yes.
8 Q. Do you remember this?
9 A. It's coming back to me.
10 Q. In your e-mail to Jeff, you
11 reference the fact that there is no
12 collaboration -- you said, I had no
13 knowledge of this.
14 Are you referring to the
15 article itself?
16 A. Yes.
17 Q. That's a yes?
18 A. Yes.
19 Q. I didn't hear you.
20 You indicate, There is no
21 collaboration with regard to the market
22 access strategy.
23 Do you see that?
24 A. Yes.

1 Q. What do you mean by --
2 A. Sorry.
3 Q. What do you mean by "market
4 access strategy"?
5 A. I mean as referenced prior,
6 where I would lead the market access
7 subteam.
8 So Jeff would have been the
9 brand director over the entire brand
10 strategy. And my portion of the market
11 access strategy was not -- is what, you
12 know, I lead, like, a subteam, for
13 example, basically.
14 Q. And so the market access
15 subteam would be dealing with how to
16 properly brand and market to the managed
17 care facility -- or managed care
18 entities, correct?
19 A. We would provide input, if
20 nothing -- so to be clear, market access,
21 my team still falls under the umbrella of
22 the brand as a total, the brand strategy,
23 minus just a subset.
24 Q. So your team is actually

1 under the brand team for Teva?

2 A. I did not report in to the
3 brand team. But I am a dotted line
4 representing the market access payer
5 strategy.

6 Q. Okay. What is -- is there a
7 line up above brand? What does it go to?
8 Or is brand one of the top --

9 MS. HILLYER: Objection to
10 the form.

11 BY MS. RUANE:

12 Q. -- entities?

13 I may not be explaining that
14 right. It may just be a bad question.
15 Let me try again.

16 What about marketing, are
17 marketing and brand on the same level?

18 A. That's the same thing,
19 sorry.

20 So when we say "brand,"
21 we're saying brand marketing, I
22 apologize.

23 Q. So your managed care
24 position had a dotted line to

1 brand/marketing?

2 A. Correct.

3 Q. The market access strategy
4 that's being discussed here as it relates
5 to managed care, were you responsible for
6 managing a budget and --

7 A. Yes.

8 Q. -- and implementing certain
9 marketing, as a result, to managed care
10 facilities?

11 A. We don't market to. We
12 would have projects associated with
13 developing a strategy. And that was the
14 budget.

15 That was what the budget was
16 used for, payer research, all sorts of
17 things along those lines.

18 Q. Do you recall, for example,
19 in the year 2015, the estimate of what
20 your budget was that you were handling?

21 MS. HILLYER: For Fentora?

22 BY MS. RUANE:

23 Q. For Fentora.

24 MS. RUANE: That's a good

1 point. Thanks.

2 MS. HILLYER: Assumes facts
3 not in evidence.

4 THE WITNESS: I would be
5 guessing if I told you. I don't
6 recall specifically. I had other
7 brands.

8 BY MS. RUANE:

9 Q. And within your budget, were
10 there line items for sales presentations?

11 A. No.

12 Q. What were the line items
13 within your budget?

14 A. They were extensive. Can
15 you be more specific of what you're
16 trying to get to? And I'll be happy --

17 Q. I'm trying to make sure I
18 understand, when you talk about the
19 market access strategy, what your -- what
20 all the responsibilities were, or
21 potential, you know, marketing, for lack
22 of a better word, that you had at your
23 disposal within your budget.

24 MS. HILLYER: Objection to

1 form. You mean as to all the
2 products that came under her
3 umbrella?

4 MS. RUANE: No.

5 BY MS. RUANE:

6 Q. Is your budget divided up by
7 product?

8 A. Yes.

9 Q. So let's take Fentora.

10 A. Yes.

11 Q. What were the kind of line
12 items or potential options that you would
13 have under the Fentora budget that you
14 managed for market access strategy?

15 MS. HILLYER: Objection to
16 form. Vague as to time frame.

17 THE WITNESS: So if --
18 specifically, the projects are
19 dependent on the time frame. So
20 if you want to give me -- if you
21 go to a long strategy, the
22 projects are different as you
23 evolve a strategy.

24 BY MS. RUANE:

1 Q. So in -- when Fentora
2 launched, let's talk about the 2007/2008
3 time frame, what types of line items
4 would have been in that budget?

5 A. It would have been the
6 development of a payer presentation
7 tactic specifically for -- at the launch,
8 it would be tactics, primarily, for the
9 account management team.

10 If there was a vendor that
11 we needed, and I don't recall, I'm giving
12 an example, for, say, a budget impact
13 model or something of that nature, those
14 are the examples.

15 But I don't have specifics
16 for you for Fentora, frankly.

17 Q. You mentioned in the e-mail
18 that the market access strategy requires
19 extensive payer research?

20 A. That's correct.

21 Q. What do you mean by that?

22 A. To develop a strategy, you
23 can either have advisory boards, you can
24 do market research, you identify -- you

1 have a third party to identify a
2 population representative of, say,
3 commercial payers. It's blinded. The
4 third party engages.

5 There are objectives and
6 research. And that research comes back
7 and it is taken into consideration as
8 you're developing your value proposition
9 for the payer and messaging.

10 That's one example.

11 Q. And you all engaged in that
12 process with the drug Fentora?

13 MS. HILLYER: Objection to
14 form.

15 THE WITNESS: That would
16 be -- that would be the norm. If
17 you're asking me specifically
18 during that time, it was a
19 partnership between marketing and
20 my role.

21 BY MS. RUANE:

22 Q. Okay. You also reference
23 targeting patient profile, message
24 testing and positioning, et cetera.

1 A. Yes.

2 Q. Explain for me what you mean
3 there.

4 A. The target patient profile,
5 you paint a picture for the physician --
6 sorry, the payer as to the appropriate
7 population where a product would be --
8 would be appropriate -- sorry,
9 appropriate for, you know, characterizing
10 the enrollment within a plan, who is the
11 appropriate patient, based on research.
12 Sometimes analogs are used.

13 I'm sorry, you asked me
14 about target patient population?

15 Q. Yes.

16 A. Payers want to quantify how
17 many patients in their plan would be
18 candidates for a therapy. So through
19 research, we're able to at least make
20 some assumptions.

21 And unless you want me to go
22 into all the details of how you do that,
23 it's extensive. You can look at analogs.
24 You can have one-on-one conversations

1 with payers. But it's all third-party
2 facilitated.

3 Q. So one of the things that
4 concerns you about the article that is
5 being referenced in your e-mail is the
6 fact that you weren't consulted on how to
7 appropriately paint the picture or
8 address market access strategy, correct?

9 A. No.

10 MS. HILLYER: Objection to
11 form.

12 BY MS. RUANE:

13 Q. You define -- or in your
14 e-mail you describe this article as a
15 promotional tactic?

16 A. I'm trying to remember where
17 it was published.

18 I'll tell you what I was
19 upset about is it was done in a vacuum,
20 and I wasn't consulted. I didn't have an
21 opinion one way or the other, as I
22 recall, about the content itself.

23 But from a role and
24 responsibility, anything that touched

1 managed care would have been -- at least
2 I would have been involved with. And
3 this was done in a silo, and that's
4 really the tone of this.

5 So why wasn't I consulted
6 and I'm hearing about it after the fact?

7 Q. You do describe the article
8 as a promotional tactic, correct?

9 A. Well, because, I guess, it
10 went through PARC and it went through --
11 I'm trying to remember where it was
12 published. Disease State Report.

13 So this is not a scientific
14 publication, as I remember. Therefore,
15 it would be considered -- it's not like
16 we would use it in promotion. It's just
17 a matter of certain publications -- our
18 medical team is the publication team. We
19 have nothing to do with that.

20 This is -- if we submit an
21 article or have -- or if there's an
22 article submitted that we had any
23 editorial content with, it's not
24 considered scientific in general.

1 Q. It's considered promotional
2 and it goes through PARC, correct?

3 A. That's what I'm told here,
4 this went through PARC.

5 Q. And what is PARC?

6 A. Promotional advertising
7 review committee. It's our
8 medical/legal/regulatory. It's just an
9 acronym.

10 Q. I'm sorry, say that again.
11 Promotional --

12 A. We have too many acronyms.
13 Promotion and advertising
14 review committee, I believe. We just
15 call it PARC. You get used to it, and
16 you don't know what it means.

17 Q. So PARC, the promotional
18 advertising review committee, you
19 mentioned medical/legal there. And I
20 want to make sure I understand what you
21 were saying.

22 Is there a medical review
23 that occurs when items are submitted to
24 PARC?

1 A. So PARC is a committee. On
2 the committee is an attorney, a regulator
3 and a medical.

4 Q. But the items that are
5 submitted to PARC are items -- the
6 submission to PARC is separate and apart
7 from items submitted through medical
8 services, correct?

9 A. Yes.

10 Q. Okay. And items submitted
11 through PARC, members of the managed care
12 team may discuss during their
13 interactions with managed care entities,
14 correct?

15 A. That would depend.

16 Q. They aren't prohibited from
17 doing so, correct?

18 A. The way our PARC works is
19 the audience has to be a part of the
20 project. So there will be sales as the
21 audience -- HCPs, so those will be sales
22 pieces. There will be managed care
23 decision-makers, that would be a piece
24 that a rep wouldn't have access to.

1 Q. And in the example here,
2 this article was submitted to PARC, was
3 then published, it looks like, maybe in a
4 managed care magazine?

5 MS. HILLYER: Objection to
6 form.

7 THE WITNESS: I really don't
8 know.

9 BY MS. RUANE:

10 Q. The link at the end says
11 Managed Care Mag.com, so.

12 Is Managed Care Magazine
13 something you're familiar with?

14 A. Yes. Yes, that would be.

15 Q. You also criticize the
16 caliber of the managed care experts and
17 indicate they would have been held to a
18 higher standard if you had the
19 opportunity to weigh in.

20 Do you see that?

21 A. I see it.

22 Q. What was your criticism of
23 the experts used?

24 A. I'd have to go back and read

1 it. I apologize, I don't remember.
 2 Q. I'll just tell you, on Page
 3 5 you can see who they are.
 4 A. Okay. Thank you.
 5 Well, I was forming an
 6 opinion based on the way, at the time, I
 7 interpreted the level of knowledge or
 8 background and the credibility,
 9 potentially.
 10 It was probably an emotional
 11 response to the fact that I wasn't
 12 involved. But I'm not familiar with
 13 either of these two individuals. And the
 14 target audience for an article like this
 15 would have been other managed care
 16 organizations.
 17 Q. It indicates -- you're
 18 familiar with Pain Matters?
 19 A. I'm familiar with it. I
 20 mean, I know of it. I had nothing to do
 21 with any -- no involvement whatsoever
 22 with Pain Matters.
 23 Q. Okay. Who was involved with
 24 Pain Matters, if you know, and the

1 Q. Do you have a general
 2 understanding that Pain Matters was used
 3 to educate and promote on the issues of
 4 chronic pain?
 5 MS. HILLYER: Objection.
 6 Calls for speculation. And lack
 7 of foundation.
 8 THE WITNESS: I've not gone
 9 on the website and gone through
 10 Pain Matters.
 11 BY MS. RUANE:
 12 Q. In your role with marketing
 13 and strategic planning, did you -- were
 14 you -- did you sit in on any meetings
 15 addressing Pain Matters and the
 16 implementation of Pain Matters?
 17 A. I recall meetings in which
 18 it would have been a cross-functional
 19 brand team meeting with updates, not
 20 content.
 21 Q. And during those updates,
 22 did you gain an understanding that Pain
 23 Matters was a campaign being launched by
 24 the company to educate on the issues of

1 implementation of that?
 2 A. The only individual that
 3 comes to mind is Matt Day. There may
 4 have been others.
 5 Q. Did you advise or serve as a
 6 supervisory role with Matt Day on Pain
 7 Matters?
 8 A. No.
 9 Q. Have you been to the Pain
 10 Matters website?
 11 A. No.
 12 Q. This e-mail references the
 13 fact that they leverage Pain Matters
 14 content.
 15 Are you aware of what
 16 Jeffrey Dierks was referring to when he
 17 said that in his response to you?
 18 MS. HILLYER: Objection.
 19 Calls for speculation.
 20 THE WITNESS: No.
 21 BY MS. RUANE:
 22 Q. So you hadn't weighed in on
 23 any Pain Matters content?
 24 A. No, no.

1 chronic pain?
 2 MS. HILLYER: Objection.
 3 Calls for speculation. Lack of
 4 foundation.
 5 THE WITNESS: I never saw
 6 anything that said, this is
 7 what -- you know, the intent. I
 8 don't recall seeing any document
 9 that said Pain Matters is intended
 10 to.
 11 BY MS. RUANE:
 12 Q. Sitting here today, do you
 13 have an understanding of what Pain
 14 Matters is?
 15 A. It's exactly as you
 16 described it, based on what I have heard.
 17 But, again, I have not gone through the
 18 website.
 19 In my role with payers, this
 20 is not something that would involve the
 21 payer community.
 22 Q. Okay. But just based on
 23 sitting in meetings and hearing updates
 24 from different departments, your memory

1 is that it's as I described it, a
2 resource to educate on chronic pain?

3 A. The way I understood it was
4 it was a resource to educate on pain.
5 That was the way I took it. I don't ever
6 recall specifically chronic pain as being
7 the focus. I don't recall.

8 Q. At the time of this e-mail
9 in 2015 --

10 A. Yep.

11 Q. -- what branded opioids for
12 chronic pain were being sold by Teva at
13 the time?

14 A. Are you asking -- oh,
15 branded. Branded for chronic pain. We
16 did not have a product for chronic pain.

17 Q. And how was this piece a
18 promotional tactic if there were no
19 branded chronic pain products on the
20 market from Teva at that time?

21 A. I can't answer that, because
22 I didn't create the -- I did not create
23 the -- I had nothing to do with the
24 article. I did not sit on the PARC team.

1 submitted it to PARC, it would be my
2 opinion, at the time -- I mean, that's
3 the way I interpreted it.

4 Q. I'm just wondering what drug
5 was being promoted, then, if there were
6 no branded opioids for chronic pain on
7 the market from Teva?

8 MS. HILLYER: Objection to
9 form.

10 THE WITNESS: The way I
11 interpret this it that it was more
12 or less talking about educating on
13 pain, not specific to any product.

14 MS. RUANE: I don't think I
15 have any further questions, but
16 Mr. Madden is going to get the
17 chance to talk to you now.

18 MS. HILLYER: Sorry. So if
19 I have redirect on some of this, I
20 should do that now, or do you want
21 me to do it after? How do you
22 want me to do that? I guess it
23 doesn't really matter --

24 MR. MADDEN: I say we go and

1 I don't know how it was presented to
2 PARC. And I don't know what criteria
3 they used for approval.

4 Q. What you know is that it
5 seemed to you to be a promotional tactic,
6 right?

7 A. It did seem to be a
8 promotional tactic.

9 Q. And that was further
10 confirmed to you by the fact that it was
11 submitted to PARC, correct?

12 A. I have no knowledge of it
13 actually being in PARC. Everything that
14 I reacted to in this is predicated on
15 this e-mail.

16 Q. And on this e-mail chain --
17 the only reason I ask that is because on
18 this e-mail chain, it indicates Matt Day
19 submitted this to PARC.

20 A. That's correct.

21 Q. So that's further indication
22 that it was promotional material being
23 provided in November of 2015, correct?

24 A. He is a marketer. If he

1 then you do your redirect.

2 MS. HILLYER: We can do
3 that. That's okay by me.

4 VIDEO TECHNICIAN: Going off
5 the record, 3:00 p.m.

6 - - -

7 (Whereupon, a brief recess
8 was taken.)

9 - - -

10 VIDEO TECHNICIAN: Back on
11 record at 3:13 p.m.

12 - - -

13 EXAMINATION

14 - - -

15 BY MR. MADDEN:

16 Q. Ms. Bearer, I'm Brian
17 Madden. I represent the plaintiffs in
18 this MDL matter.

19 I am not going to ask you
20 questions that prior counsel asked you,
21 but just have a few things for you.

22 You started at Cephalon in
23 2003 --

24 A. Correct.

1 Q. -- correct?
 2 A. Yes.
 3 Q. And you were in managed care
 4 from the beginning?
 5 A. Yes.
 6 Q. You were at Cephalon when
 7 the company pleaded guilty with regard to
 8 off-label prescription of drugs,
 9 including Actiq?
 10 MS. HILLYER: Objection to
 11 form.
 12 BY MR. MADDEN:
 13 Q. Is that true?
 14 A. I was employed, yes.
 15 Q. Yes.
 16 Were you made aware of that
 17 guilty plea at the time of your
 18 employment?
 19 A. Yes.
 20 Q. And that was in
 21 approximately the fall of 2008; is that
 22 right?
 23 A. I believe so, yes.
 24 Q. Were you disciplined at all

1 with regard to that guilty plea for
 2 off-label marketing of Actiq?
 3 A. No.
 4 Q. Did you lose your job as a
 5 result of that guilty plea?
 6 A. No.
 7 Q. Who did lose their job at
 8 Cephalon as a result of that guilty plea?
 9 MS. HILLYER: Objection.
 10 Calls for speculation.
 11 THE WITNESS: I really don't
 12 know.
 13 BY MR. MADDEN:
 14 Q. Do you know of anyone at
 15 Cephalon who lost their job as a result
 16 of the off-label marketing guilty plea
 17 for Actiq?
 18 MS. HILLYER: Objection.
 19 Calls for speculation.
 20 THE WITNESS: I really don't
 21 know.
 22 BY MR. MADDEN:
 23 Q. Prior to 2008, in your role
 24 in managed care, were you made aware by

1 the company of the rules with regard to
 2 off-label marketing versus on-label
 3 marketing?
 4 A. Yes.
 5 Q. You were trained on that?
 6 A. Yep.
 7 Q. Did you take modules
 8 regarding that?
 9 A. I don't remember
 10 specifically. Most likely, yes. We take
 11 a lot of modules.
 12 When you're talking time
 13 frame, I just don't have the specific
 14 time frame.
 15 Q. But it's fair to say you
 16 knew, prior to 2008, what the rules were
 17 with regard to legal, on-label marketing
 18 of a drug like Actiq; is that true?
 19 A. Yes.
 20 Q. Now, two documents that Ms.
 21 Ruane discussed with you, let's first
 22 look at Exhibit-12.
 23 And I believe you have paper
 24 versions, but we can also put them up on

1 the screen, if that helps you.
 2 A. It's easier for me, if you
 3 don't mind, to read the hard copies.
 4 MS. HILLYER: They are
 5 numbered on the bottom. It should
 6 be in order.
 7 THE WITNESS: I see. I got
 8 it.
 9 MS. HILLYER: It's this one.
 10 THE WITNESS: The dossier.
 11 BY MR. MADDEN:
 12 Q. Exhibit-12 was marked as the
 13 Actiq managed care dossier, correct?
 14 A. That's correct.
 15 Q. And do I recall your
 16 testimony correctly that a dossier such
 17 as this would be sent to a managed care
 18 provider if they requested it?
 19 A. That's correct.
 20 Q. This was not promoted to a
 21 managed care entity, but, rather, if they
 22 asked for it, this would be sent by the
 23 company to them; is that true?
 24 A. Yes.

<p style="text-align: right;">Page 289</p> <p>1 Q. And if any of the issues</p> <p>2 discussed on Page 1 of Exhibit-12 were</p> <p>3 requested from Cephalon, this would be</p> <p>4 sent to the managed care provider,</p> <p>5 correct?</p> <p>6 A. I'm sorry, what?</p> <p>7 Q. Bad question.</p> <p>8 If a managed care provider</p> <p>9 had a question about any of the subjects</p> <p>10 on Page 1 of Exhibit-12, they could ask</p> <p>11 the company for this dossier, correct?</p> <p>12 A. Let me rephrase.</p> <p>13 If they had a question on,</p> <p>14 say, breakthrough pain specifically --</p> <p>15 Q. Yes.</p> <p>16 A. -- they wouldn't necessarily</p> <p>17 know what was in the dossier. Typically,</p> <p>18 when they request the dossier, they</p> <p>19 request the dossier.</p> <p>20 Q. Fair enough.</p> <p>21 A. Okay.</p> <p>22 Q. If a managed care entity or</p> <p>23 payer had a question under Section 5.0,</p> <p>24 Risk of opioid abuse by patients with</p>	<p style="text-align: right;">Page 290</p> <p>1 chronic pain, and that question were</p> <p>2 submitted to Cephalon, then Cephalon</p> <p>3 could send this dossier to that managed</p> <p>4 care entity, correct?</p> <p>5 MS. HILLYER: Objection to</p> <p>6 the extent it calls for</p> <p>7 speculation outside her knowledge.</p> <p>8 THE WITNESS: I don't know.</p> <p>9 This was handled through medical,</p> <p>10 not through my side of the</p> <p>11 business.</p> <p>12 BY MR. MADDEN:</p> <p>13 Q. We can look at the dossier.</p> <p>14 And if this dossier went to</p> <p>15 a managed care entity, it does discuss</p> <p>16 risk of opioid abuse by patients --</p> <p>17 A. Yes, it does.</p> <p>18 Q. -- for chronic pain, true?</p> <p>19 And if we go to Page 23 of</p> <p>20 this document.</p> <p>21 MR. MADDEN: The last</p> <p>22 sentence, last two sentences</p> <p>23 before Section 5.2, would you</p> <p>24 highlight those for me, please?</p>
<p style="text-align: right;">Page 291</p> <p>1 THE WITNESS: I'm sorry, say</p> <p>2 that again.</p> <p>3 BY MR. MADDEN:</p> <p>4 Q. Beginning with, Extensive.</p> <p>5 A. Extensive clinical</p> <p>6 experience with the use -- you want me to</p> <p>7 read it?</p> <p>8 MS. HILLYER: No. He was</p> <p>9 asking him to highlight that.</p> <p>10 She wasn't aware of that.</p> <p>11 MR. MADDEN: I'm actually</p> <p>12 talking to the tech.</p> <p>13 BY MR. MADDEN:</p> <p>14 Q. Ms. Bearer, I point your</p> <p>15 attention, in Exhibit-12, to the</p> <p>16 highlighted language from Page 23 in the</p> <p>17 Actiq dossier which says, Extensive</p> <p>18 clinical experience with the use of</p> <p>19 opioids for patients with cancer pain</p> <p>20 indicates that the risk of addiction in</p> <p>21 this population is very low. Similarly,</p> <p>22 the risk of abuse is low in patients with</p> <p>23 nonmalignant pain, though there is less</p> <p>24 experience in this patient population.</p>	<p style="text-align: right;">Page 292</p> <p>1 Do you see that language?</p> <p>2 A. Yes, I do.</p> <p>3 Q. Now, we also looked at</p> <p>4 another exhibit that you prepared,</p> <p>5 Exhibit-20, which was a slide</p> <p>6 presentation with regard to Vantrela.</p> <p>7 Do you recall that?</p> <p>8 A. Yes.</p> <p>9 Q. And you accumulated data and</p> <p>10 put that data into your slides and cited</p> <p>11 to that data with regard to --</p> <p>12 A. Yes.</p> <p>13 Q. -- opioid abuse and</p> <p>14 diversion, correct?</p> <p>15 A. Correct.</p> <p>16 MS. HILLYER: Objection to</p> <p>17 form.</p> <p>18 BY MR. MADDEN:</p> <p>19 Q. So let's pull up Exhibit-20.</p> <p>20 And I'll reference you to Page 09183260.</p> <p>21 A. I'm out of order here.</p> <p>22 MS. HILLYER: One second</p> <p>23 here.</p> <p>24 260? Sorry, do you have</p>

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1 the -- so this is Exhibit-20. So
 2 it should be --
 3 - - -
 4 (Whereupon, a discussion off
 5 the record occurred.)
 6 - - -
 7 BY MR. MADDEN:
 8 Q. Ms. Bearer, this is part of
 9 the slide deck you put together with
 10 regard to Vantrela, correct?
 11 A. That's correct.
 12 Q. And Vantrela was an
 13 abuse-deterrent opioid that was developed
 14 by Teva, correct?
 15 A. Correct. Yes.
 16 Q. Okay. This is one of the
 17 slides you put together, right?
 18 A. Yes.
 19 We're on 60?
 20 MS. HILLYER: Yes. The
 21 Bates number is 60.
 22 MR. MADDEN: Yes, ma'am.
 23 THE WITNESS: Yes.
 24 BY MR. MADDEN:

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1 A. I do.
 2 Q. Would you agree with me that
 3 those are contradictory messages?
 4 MS. HILLYER: Objection to
 5 form. Lack of foundation as to
 6 Exhibit-12. She testified she had
 7 nothing to do with that document
 8 and has no knowledge of it. It
 9 calls for speculation.
 10 BY MR. MADDEN:
 11 Q. I'll ask the question again.
 12 Would you agree with me that
 13 those are contradictory messages?
 14 MS. HILLYER: Same
 15 objections.
 16 THE WITNESS: I can tell you
 17 that the date referenced in the
 18 most recent is much -- is recent.
 19 I don't know the date of the
 20 original document, because I
 21 didn't create it.
 22 So the data it's talking
 23 about in the dossier was several
 24 years prior to this information.

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1 Q. The top rectangle has some
 2 language that says, Opioids have a high
 3 rate of abuse and generate enormous
 4 costs. Almost 12 percent of opioid
 5 patients become addicted.
 6 Do you see that?
 7 A. I do.
 8 Q. Let's compare that with what
 9 we saw in Exhibit-12, side by side.
 10 A. Okay.
 11 MR. MADDEN: So if you could
 12 go back and highlight the
 13 language?
 14 MS. HILLYER: Do you need
 15 Exhibit-12?
 16 THE WITNESS: I know what it
 17 says.
 18 BY MR. MADDEN:
 19 Q. We have this language about
 20 a high rate of abuse with opioid use and
 21 this language from Exhibit-12, which was
 22 the Actiq managed care dossier, which
 23 talks about a low risk of abuse.
 24 Do you see that?

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1 BY MR. MADDEN:
 2 Q. All right. Would you agree
 3 with me that the information is
 4 contradictory, regardless of the dates?
 5 MS. HILLYER: Same
 6 objections. And objection to
 7 form.
 8 THE WITNESS: I believe
 9 it's -- new data is available and
 10 it's more up to date and more
 11 recent, and it's cited. There's
 12 no citation in the dossier that I
 13 can comment on.
 14 BY MR. MADDEN:
 15 Q. Let's look -- let's go back
 16 to Exhibit-12, that same page, 23.
 17 A. Yep.
 18 Q. Under managing the risk of
 19 opioid abuse, the first sentence says,
 20 Although it is uncommon for chronic pain
 21 patients to abuse opioid medication,
 22 there is a potential risk associated with
 23 the use of all opioids.
 24 Do you see that?

1 A. Yes, I do.
 2 Q. Now, let's look at the slide
 3 you put together in the Exhibit-20, the
 4 following page, which is the Bates number
 5 ending in 61.
 6 A. Yep. Yes.
 7 MR. MADDEN: So if you can
 8 highlight that first sentence for
 9 me?
 10 THE WITNESS: Yep.
 11 BY MR. MADDEN:
 12 Q. And then the slide we see on
 13 the right is a slide you put together for
 14 Vantrela, correct?
 15 A. Yep.
 16 Q. And you put in that slide
 17 the at-risk subpopulation within chronic
 18 pain is estimated to be about 27 percent
 19 or 602 members per 100,000 plan members.
 20 Do you see that?
 21 A. I do.
 22 Q. And the risk you're talking
 23 about there for chronic pain patients is
 24 abuse to opioids, correct?

1 BY MR. MADDEN:
 2 Q. Were you a part of that
 3 decision-making?
 4 A. No, no.
 5 Q. Would you agree with me that
 6 Vantrela was designed, according to your
 7 slides, to help reduce the risk of abuse
 8 of opioids?
 9 A. It was to illustrate that
 10 there was an unmet need, potentially, for
 11 treatment options for physicians for
 12 patients in which they wanted to
 13 prescribe a long-acting opioid in an
 14 abuse-deterrent formulation.
 15 Q. Right. But we've looked at
 16 two slides in your PowerPoint --
 17 A. Yep.
 18 Q. -- specifically dealing
 19 with --
 20 MS. HILLYER: Let him
 21 finish.
 22 THE WITNESS: Sorry.
 23 BY MR. MADDEN:
 24 Q. -- the incidence of abuse

1 A. Yes.
 2 Q. Would you agree with me that
 3 those two messages are contradictory?
 4 MS. HILLYER: Objection to
 5 form. And also lack of foundation
 6 as to Exhibit-12.
 7 THE WITNESS: And I'll
 8 repeat my answer, which is the --
 9 I don't remember the name, the one
 10 to the right of me, the at-risk
 11 subpopulation of chronic pain has
 12 a reference. It's recent. And I
 13 don't know the date of the, or the
 14 reference from the previous
 15 document, as I did not create it.
 16 BY MR. MADDEN:
 17 Q. Did Vantrela launch?
 18 A. No.
 19 Q. Why?
 20 MS. HILLYER: Objection to
 21 the extent it calls for
 22 speculation.
 23 THE WITNESS: Yes. I had no
 24 part in that decision --

1 for opioid users, correct?
 2 A. Correct.
 3 Q. So Vantrela, at least
 4 according to your slides, was designed,
 5 at least in part, to deal with that risk
 6 of abuse, correct?
 7 A. It was designed, yes, to
 8 create a treatment option for physicians
 9 to prescribe to patients as they deemed
 10 appropriate. It was a non -- that was an
 11 abuse-deterrent formulation.
 12 Q. Was there a concern that
 13 managed care payers wouldn't pay for
 14 Vantrela?
 15 MS. HILLYER: Objection to
 16 form.
 17 THE WITNESS: As with any
 18 new product, payers are always
 19 scrutinizing whether they'll pay
 20 for any branded product.
 21 BY MR. MADDEN:
 22 Q. Am I correct that one of the
 23 reasons Vantrela did not launch was
 24 because there was concern within the

1 company, Teva, that third-party payers
2 would not pay for Vantrela?

3 MS. HILLYER: Objection.
4 Calls for speculation. And lack
5 of foundation. She testified she
6 didn't know why and she wasn't
7 part of that decision.

8 BY MR. MADDEN:

9 Q. Do you know one way or the
10 other?

11 A. I was not part of the
12 decision. I was not part of the
13 decision.

14 Q. To your knowledge, was the
15 Pain Matters campaign run, in part, to
16 support Teva's generic portfolio?

17 MS. HILLYER: Objection to
18 form. Calls for speculation. And
19 lack of foundation. She testified
20 she wasn't part of that.

21 THE WITNESS: I have no
22 knowledge of that.

23 BY MR. MADDEN:

24 Q. So as you sit here today,

1 you don't know why the Pain Matters
2 campaign was run, as far as supporting
3 any particular product?

4 A. As far as supporting any
5 particular product, that's correct.

6 MR. MADDEN: All right.
7 I'll pass the witness.

8 VIDEO TECHNICIAN: Going off
9 the record --

10 MS. HILLYER: Can I just do
11 my redirect? You can stay on the
12 record, unless you need to change
13 anything on the record.

14 THE WITNESS: Do I look
15 straight ahead?

16 MS. HILLYER: Yes. I'm not
17 going to move over there.

18 - - -

19 EXAMINATION

20 - - -

21 BY MS. HILLYER:

22 Q. Ms. Bearer, earlier you
23 testified about an MEP.

24 Do you recall that?

1 A. I do.

2 Q. Can you explain again what
3 an MEP is?

4 A. A medical education program.

5 Q. And in your work at Teva and
6 Cephalon, that would have been in the
7 context of managed care programs?

8 A. Yes.

9 Q. And how would an MEP have
10 come about for a managed care program?

11 A. If a health plan, payer,
12 requested information on any given
13 product, a MIRF would be submitted. And
14 at that point, someone from medical is
15 required to present a medical education
16 program.

17 Q. Would MEPs have been
18 presented by anybody on the market access
19 team?

20 A. No.

21 Q. So they would only be
22 presented to managed care upon an
23 unsolicited request?

24 A. That's correct.

1 Q. Earlier you also testified
2 about the Actiq white paper.

3 Do you recall that?

4 A. I do.

5 Q. How, if at all, was the
6 Actiq white paper used in connection with
7 managed care organizations?

8 A. Again, upon an unsolicited
9 request, if an account manager is
10 speaking to a payer and they had specific
11 questions relative to any given product
12 that was either -- that the -- at the
13 point in time the account manager could
14 not speak to, they would put a MIRF
15 through -- I'm sorry, medical information
16 request form, and which, then, the white
17 paper would be sent directly to the payer
18 who requested it.

19 Q. And earlier you looked at
20 sections of the Actiq managed care
21 dossier in Exhibits-11 and 12.

22 Do you recall that?

23 A. I do.

24 Q. And just to clarify, what,

1 if any, involvement did you have in
 2 creating those documents?
 3 A. None.
 4 Q. Do you know if the versions
 5 that are in Exhibit-11 and 12 are final
 6 versions?
 7 A. No, I don't.
 8 Q. Do you know if the versions
 9 at 11 and 12, Exhibits-11 and 12, were
 10 provided to any payers?
 11 A. I -- no.
 12 Q. And over the course of the
 13 day, Ms. Bearer, there was some testimony
 14 around discussions you or members of the
 15 market access team might have had with
 16 managed care payers.
 17 Would you or members of
 18 managed -- the market access team at Teva
 19 or Cephalon ever have substantive
 20 discussions concerning the standard of
 21 care for disease states other than
 22 breakthrough pain in cancer patients who
 23 are opioid tolerant in the context of
 24 Actiq or Fentora?

1 access team have had substantive
 2 discussions concerning acute pain with
 3 managed care entities, in the context of
 4 Actiq or Fentora, to your knowledge?
 5 MS. RUANE: Same objection.
 6 MS. HILLYER: You can
 7 answer.
 8 THE WITNESS: Not to my
 9 knowledge.
 10 BY MS. HILLYER:
 11 Q. And did Cephalon or Teva
 12 have a policy around those types of
 13 discussions with managed care entities?
 14 A. Yes.
 15 Q. What was that?
 16 A. If it was not an approved
 17 product and/or approved indication, if a
 18 question was raised, the policy states
 19 that you would say -- you would respond
 20 by saying that we're not indicated for
 21 whatever the question was, and if you
 22 needed additional information, I'm happy
 23 to send a MIRF; again, medical
 24 information request form.

1 A. No.
 2 MS. RUANE: Object to the
 3 form.
 4 BY MS. HILLYER:
 5 Q. Would you have had
 6 substantive discussions regarding chronic
 7 pain in the context of Actiq or Fentora?
 8 A. No.
 9 Q. Would members of the market
 10 access team, to your knowledge, have
 11 substantive discussions concerning
 12 chronic pain, in the context of Actiq or
 13 Fentora, with managed care entities?
 14 MS. RUANE: Object to form.
 15 THE WITNESS: No.
 16 BY MS. HILLYER:
 17 Q. And would you have had
 18 substantive discussions concerning acute
 19 pain with managed care entities in the
 20 context of Actiq or Fentora?
 21 MS. RUANE: Object to form.
 22 THE WITNESS: No.
 23 BY MS. HILLYER:
 24 Q. Would members of the market

1 Q. And then, lastly, we talked
 2 a little bit about Exhibit-16, which was
 3 titled, Managed Care Presentation, Draft
 4 for Review.
 5 Just to clarify, did you
 6 understand this to be a promotional
 7 document?
 8 A. No. This is, to me,
 9 presented by a speaker.
 10 MS. HILLYER: I have no
 11 further questions at this time.
 12 MS. RUANE: Just a few
 13 follow-up, briefly.
 14 - - -
 15 EXAMINATION
 16 - - -
 17 BY MS. RUANE:
 18 Q. To be presented by -- the
 19 last document you were looking at, that
 20 would be to be presented by a speaker who
 21 would be a physician compensated by Teva,
 22 correct?
 23 A. Correct.
 24 Q. Do you know how much the

1 physicians were compensated for speaking
2 and presenting slide decks like the one
3 before you?

4 A. Fair market value. I don't
5 know what that was.

6 Q. Do you know how fair market
7 value was calculated?

8 A. No.

9 Q. You mentioned that there was
10 a policy regarding an approach -- or a
11 response if there were questions about
12 something beyond the indication.

13 Is that a written policy?

14 A. I can't recall --

15 MS. HILLYER: Objection to
16 form as to time.

17 BY MS. RUANE:

18 Q. You can answer if you know.

19 A. I don't recall -- what time
20 frame are you talking about? Because --

21 Q. Let's start during the time
22 frame of Teva.

23 Does Teva have a written
24 policy, to your knowledge, regarding the

1 approach taken when a managed care entity
2 has questions about something beyond the
3 indication of a drug?

4 A. We do have a managed care
5 reimbursement policy.

6 Q. Is that the title of it,
7 managed care reimbursement policy?

8 A. I don't recall the exact
9 title of it.

10 Q. Do you believe that that
11 managed care reimbursement policy has,
12 the policy, a written policy within that
13 consistent with what you just described?

14 A. To the best of my knowledge.
15 I have not read it recently.

16 Q. What about during the time
17 of Cephalon, was there a written policy
18 at that time?

19 A. I don't recall if it was
20 written or not.

21 Q. You don't have a specific
22 memory of a written policy, during the
23 time that the company was Cephalon,
24 instructing the managed care folks on

1 what to do if a managed care entity had a
2 question about something beyond the
3 indication?

4 MS. HILLYER: Objection to
5 the form. You're talking about a
6 long time frame.

7 But you can answer.

8 THE WITNESS: You're asking
9 if there was a written policy?

10 BY MS. RUANE:

11 Q. Yes.

12 A. I don't recall if it was
13 written. I just don't recall if it was
14 written.

15 Q. Is there anything you can
16 think of where we could look to see a
17 document to confirm your memory that that
18 policy would have existed at the time
19 that the company was Cephalon?

20 A. Old documents. I don't
21 recall who -- again, we're talking about
22 a long span of time, and there's been an
23 evolution of modules and training and
24 sign-offs on various policies.

1 Whoever in the organization
2 is -- compliance, typically, would be
3 the -- I would think -- and, again,
4 that's -- my first answer would be
5 compliance.

6 Q. Okay.

7 MS. RUANE: Thank you.
8 Nothing further.

9 VIDEO TECHNICIAN: Going off
10 record. 3:37 p.m.

11 - - -

12 (Whereupon, a discussion off
13 the record occurred.)

14 - - -

15 VIDEO TECHNICIAN: Back on
16 record. 3:38 p.m.

17 - - -

18 EXAMINATION

19 - - -

20 BY MR. GASTEL:

21 Q. Good afternoon. My name is
22 Ben Gastel, representing the plaintiffs
23 in the Tennessee cases that have been
24 cross-noticed into this deposition today.

1 MR. GASTEL: And I first
 2 want to state, for the record,
 3 that I object to the deposition,
 4 on behalf of my clients, going
 5 forward today due to Teva's
 6 continuous failures to meet its
 7 obligations as set forth in the
 8 state and federal cooperation
 9 protocol, as laid out in our
 10 previous deposition records and
 11 our pending motions to quash.
 12 With that objection in mind,
 13 I do have a handful of questions
 14 for you. Hopefully we will be
 15 relatively short. I assure you, I
 16 will not be as long as your
 17 previous questioners today.
 18 BY MR. GASTEL:
 19 Q. As I stated, Ms. Bearer, the
 20 group of plaintiffs that I'm representing
 21 are located in Tennessee.
 22 So I want to start, in your
 23 work with Teva or Cephalon, did you ever
 24 have the opportunity to travel to the

1 public health concern whenever
 2 prescription opioids are consumed for
 3 nonmedical purposes?
 4 MS. HILLYER: Objection to
 5 form.
 6 THE WITNESS: Can you define
 7 "nonmedical purposes"?
 8 BY MR. GASTEL:
 9 Q. Well, in your mind, what are
 10 the nonmedical reasons a person would
 11 consume a prescription opioid?
 12 MS. HILLYER: Objection to
 13 form.
 14 THE WITNESS: You asked the
 15 question, so if you could just
 16 give me the context of the
 17 question.
 18 BY MR. GASTEL:
 19 Q. Well, sure. And so let's
 20 take it in two parts here.
 21 In your mind, what are the
 22 nonmedical reasons that a person would
 23 consume a prescription opioid?
 24 MS. HILLYER: Objection to

1 state of Tennessee for your work?
 2 A. Not that I recall.
 3 Q. Would you agree that it's a
 4 public health concern whenever
 5 prescription opioids are illegally
 6 diverted and consumed for nonmedical
 7 purposes?
 8 MS. HILLYER: Objection to
 9 form.
 10 THE WITNESS: Say it --
 11 repeat the question to make sure I
 12 answer you correctly.
 13 BY MR. GASTEL:
 14 Q. Sure.
 15 Would you agree that it's a
 16 public health concern whenever
 17 prescription opioids are illegally
 18 diverted and consumed for nonmedical
 19 purposes?
 20 MS. HILLYER: Same
 21 objection.
 22 THE WITNESS: Yes.
 23 BY MR. GASTEL:
 24 Q. Would you agree that it's a

1 form. Calls for speculation.
 2 THE WITNESS: That would be
 3 speculating.
 4 BY MR. GASTEL:
 5 Q. So you don't have in your
 6 mind any reason why somebody would
 7 consume an opioid for a nonmedical
 8 reason?
 9 MS. HILLYER: Objection to
 10 form. Calls for speculation.
 11 THE WITNESS: Again,
 12 individuals have different reasons
 13 for that behavior. I can't speak
 14 to it.
 15 BY MR. GASTEL:
 16 Q. Do you have any
 17 understanding about why individuals
 18 consume opioids for nonmedical purposes?
 19 MS. HILLYER: Same
 20 objections. And now asked and
 21 answered.
 22 THE WITNESS: Again, I
 23 could -- there are probably
 24 numerous reasons. And I don't

1 have any personal knowledge,
 2 personally, of consuming opioids
 3 for nonmedical reasons.
 4 BY MR. GASTEL:
 5 Q. Can you get high from
 6 consuming prescription opioids?
 7 MS. HILLYER: Objection.
 8 Calls for speculation.
 9 THE WITNESS: I have no
 10 personal knowledge of whether
 11 someone can get high or not, based
 12 personally on my own experience.
 13 BY MR. GASTEL:
 14 Q. And you've never heard of
 15 people getting high off of prescription
 16 opioids?
 17 A. I hear a lot of things. So,
 18 again, you're asking me specifically
 19 about my interpretation of getting high.
 20 And I -- as far as having an
 21 opinion about that, I know what I hear in
 22 the media. But no personal experience
 23 with that.
 24 Q. I'm not asking you if you've

1 ever been high.
 2 I'm asking you if you have
 3 an understanding of whether or not people
 4 get high from prescription opioids?
 5 MS. HILLYER: Hold on.
 6 Asked and answered. She's
 7 testified that she's heard in the
 8 news about this, she has no
 9 personal experience.
 10 She's here as a fact witness
 11 to testify about her personal
 12 experience.
 13 If you want to ask her about
 14 that, go ahead. But she's
 15 answered your question.
 16 MR. GASTEL: Are you
 17 directing her not to answer?
 18 MS. HILLYER: No.
 19 BY MR. GASTEL:
 20 Q. You can answer.
 21 A. I have no personal
 22 experience relative to individuals
 23 getting high off of opioids.
 24 Q. In 2015, did you believe

1 that there was a public health crisis of
 2 abuse and addiction as it relates to
 3 opioids?
 4 MS. HILLYER: Objection to
 5 form.
 6 THE WITNESS: Did I have a
 7 personal -- repeat it, I'm sorry.
 8 I'm just --
 9 BY MR. GASTEL:
 10 Q. In 2015 --
 11 A. 2015.
 12 Q. -- did you believe that
 13 there was a public health crisis of abuse
 14 and addiction as it relates to opioids?
 15 MS. HILLYER: Same
 16 objection.
 17 THE WITNESS: Yeah, I
 18 don't -- you're asking my personal
 19 belief?
 20 BY MR. GASTEL:
 21 Q. Yes.
 22 A. Again, with no firsthand
 23 knowledge, but data would suggest, in the
 24 public domain, that that is correct.

1 Q. I'll show you a document
 2 that we'll mark as Exhibit-22.
 3 - - -
 4 (Whereupon, Teva-Bearer
 5 Exhibit-22,
 6 TEVA_MDL_A_09218160-165, was
 7 marked for identification.)
 8 - - -
 9 MR. GASTEL: I've got a copy
 10 for you, too.
 11 MS. HILLYER: Thank you.
 12 BY MR. GASTEL:
 13 Q. You see that Exhibit-22 is
 14 an e-mail that you sent to various
 15 individuals on June 4th, 2015?
 16 Do you see that?
 17 A. I do see that.
 18 Q. And the subject is the Time
 19 Magazine Cover Story, Why America Can't
 20 Kick Its Painkiller Problem.
 21 Did I read that correctly?
 22 A. Yes.
 23 Q. And then in the subject of
 24 the e-mail you write, All, more news

1 highlighting the public health crisis of
 2 abuse and addiction. Regards, Deb.
 3 Did I read that correctly?
 4 A. You did.
 5 Q. And the e-mail goes on to
 6 forward this cover story for Time
 7 Magazine.
 8 And if we go to the last
 9 page of this exhibit, there is a picture
 10 of the cover of the Time Magazine
 11 article, and the cover says, They're the
 12 most powerful painkillers ever invented
 13 and they're creating the worst addiction
 14 crisis America has ever seen.
 15 Did I read that correctly?
 16 A. Yes.
 17 Q. And you forwarded this to
 18 some of your colleagues at Teva, correct?
 19 A. Yep.
 20 Q. And it looks like you also
 21 included some people from Insight
 22 Strategies?
 23 A. Yes.
 24 Q. Who are Steve Reid and Harry

1 Schiavi?
 2 A. Yes, Schiavi.
 3 They work for a managed
 4 care -- they are strategic partners, a
 5 third party, that have conducted payer
 6 research, analog assessment, et cetera.
 7 Q. So they were a vendor --
 8 A. Correct.
 9 Q. -- that Teva would use as
 10 part of its marketing and promotion to
 11 managed care organizations?
 12 A. Correct.
 13 Q. And why did you think it was
 14 important that they saw this Time
 15 Magazine article?
 16 MS. HILLYER: Objection to
 17 form.
 18 THE WITNESS: As I stated
 19 previously, there was a lot of
 20 information in the public domain
 21 concerning this. And, therefore,
 22 I felt it was important, as we as
 23 an organization were looking at
 24 abuse, this was in preparation for

1 Vantrela. That would be the
 2 reason.
 3 BY MR. GASTEL:
 4 Q. Sure.
 5 And then -- now that you've
 6 looked at this e-mail, does this refresh
 7 your recollection that in 2015 you
 8 believed that there was a public health
 9 crisis of abuse and addiction?
 10 A. I said this is news
 11 highlighting the public crisis, that was
 12 in the public domain.
 13 You asked me previously if
 14 it was my personal. And I answered the
 15 question that I have no personal
 16 experience with any individual or
 17 individuals experiencing opioid
 18 addiction.
 19 Q. And that's fine.
 20 But you're the one who chose
 21 the language that's used in this e-mail,
 22 right?
 23 A. That's correct.
 24 Q. And if you didn't believe

1 that we were in the midst of a public
 2 health crisis of abuse and addiction, why
 3 did you use that in your e-mail?
 4 A. I didn't say that --
 5 MS. HILLYER: Objection to
 6 form.
 7 THE WITNESS: What I'm
 8 saying to you is, this is the type
 9 of information that payers are
 10 also -- it's public information.
 11 And as it relates to our
 12 customers, they read this
 13 information as well.
 14 BY MR. GASTEL:
 15 Q. I want to go through some of
 16 the things that this article highlights.
 17 The last paragraph on the
 18 first page ending in 160, do you see
 19 where it starts, This is not?
 20 Are you with me?
 21 A. That paragraph, yes. This
 22 is not a story.
 23 Q. It says, This is not a story
 24 about dark alleys and drug dealers. It

1 starts in doctors' offices with everyday
 2 people seeking relief from pain and
 3 suffering. Around the nation, doctors so
 4 frequently prescribe the drugs known as
 5 opioids for chronic pain from conditions
 6 like arthritis, migraines, and lower back
 7 injuries, that there are enough pills
 8 prescribed every year to keep every
 9 American adult medicated around the clock
 10 for a month.

11 Did I read that correctly?

12 A. You did.

13 Q. When you forwarded this
 14 article to your colleagues at Teva and
 15 your third-party vendors that you worked
 16 with, did you agree with that statement
 17 in this article?

18 MS. HILLYER: Objection to
 19 form.

20 THE WITNESS: That's not
 21 referenced. It's simply what was
 22 written.

23 If they put a reference, I
 24 would have more reason to have an

1 opinion. I would have an opinion.

2 BY MR. GASTEL:

3 Q. The paragraph goes on there,
 4 The longer patients stay on the drugs,
 5 which are chemically related to heroin
 6 and trigger a similar biological
 7 response, including euphoria, the higher
 8 the chances users will become addicted.

9 Did I read that correctly?

10 A. You did.

11 Q. When you forwarded this
 12 article to your colleagues at Teva and
 13 your third-party vendors, did you agree
 14 with this statement made in this article?

15 MS. HILLYER: Objection to
 16 form.

17 THE WITNESS: I didn't have
 18 an opinion about this statement
 19 when I forwarded the e-mail.

20 BY MR. GASTEL:

21 Q. Do you have an opinion now?

22 A. There's no reference here
 23 specific to what they're quoting. And as
 24 I mentioned earlier, there's a lot of

1 information in the public domain, which
 2 we take seriously, and we, obviously,
 3 were looking at an abuse-deterrent
 4 treatment option for patients physicians
 5 deemed appropriate for an abuse-deterrent
 6 formulation of opioids.

7 Q. Are you done?

8 A. Yeah, I'm sorry.

9 Q. That's all right. I was
 10 just making sure you were done.

11 The article goes on. When
 12 doctors, regulators and law enforcement
 13 officials try to curb access, addicted
 14 patients buy pills on the black market,
 15 where they are plentiful.

16 Did I read that correctly?

17 A. Yes, you did.

18 Q. When you forwarded this
 19 article to your colleagues at Teva and
 20 your third-party vendors, did you agree
 21 with this statement made in this article?

22 MS. HILLYER: Objection to
 23 form.

24 THE WITNESS: I didn't have

1 an opinion about that -- that
 2 statement.

3 BY MR. GASTEL:

4 Q. Going down farther into the
 5 next paragraph, the sentence beginning,
 6 Of the 9.4 million Americans who take
 7 opioids.

8 Do you see that?

9 A. Where am I looking at?

10 Q. The third line down,
 11 three-quarters of the page over.

12 A. I see it. Thank you.

13 Q. It says, Of the 9.4 million
 14 Americans who take opioids for long-term
 15 pain, 2.1 million are estimated by The
 16 National Institutes of Health to be
 17 hooked and are in danger of turning to
 18 the black market.

19 Did I read that correctly?

20 A. Yes.

21 Q. When you forwarded this
 22 article to your colleagues at Teva, did
 23 you have any reason to dispute this
 24 statistic from The National Institutes of

1 Health as relayed by this Time Magazine
2 article?

3 MS. HILLYER: Objection to
4 form. Lack of foundation.

5 THE WITNESS: Did I have any
6 reason to dispute it?

7 BY MR. GASTEL:

8 Q. Yes.

9 A. Again, other than the
10 reference to The National Institutes of
11 Health, of which I've not seen the actual
12 data, this is just a statement to me, of
13 which I don't have an opinion if it's
14 accurate or not.

15 Q. Did you ever tell any of
16 your colleagues that you thought that The
17 National Institutes of Health was
18 overestimating the number of Americans
19 that are hooked and in danger of turning
20 to the black market?

21 A. I don't have any
22 recollection of having a conversation.

23 Q. Going down, skipping down
24 two paragraphs with the paragraph

1 beginning, All now agree.

2 Do you see that?

3 A. Yes.

4 Q. About a quarter of the way
5 down the page.

6 All now agree that the
7 opioid epidemic is a terrible problem,
8 but few are taking responsibility. It
9 has fallen to local law enforcement and
10 health professionals to clean up the mess
11 as addiction and abuse ravage their
12 communities.

13 Did I read that correctly?

14 A. Yes, you did.

15 Q. When you forwarded this
16 e-mail to your colleagues at Teva and
17 your third-party vendors, did you have
18 any reason to dispute that claim in the
19 Time Magazine article?

20 MS. HILLYER: Same
21 objections.

22 THE WITNESS: Once again,
23 there's no specific reference to
24 where they cite this data.

1 Therefore, I don't have an
2 opinion.

3 BY MR. GASTEL:

4 Q. Did you tell any of your
5 colleagues, or do you recall telling any
6 of your colleagues, that you thought Time
7 Magazine was wrong when they claimed that
8 local law enforcement and health
9 professionals were left to clean up the
10 mess?

11 MS. HILLYER: Objection to
12 form.

13 THE WITNESS: I don't recall
14 having any conversation.

15 BY MR. GASTEL:

16 Q. I'm going to flip over to
17 the next page, the one ending with Bates
18 stamp 162.

19 A. Okay.

20 Q. And about halfway down,
21 there's a paragraph beginning, In some
22 cases.

23 Do you see that paragraph?

24 A. I'll read it here.

1 Okay. Got it. Thank you.

2 Q. It says, In some cases,
3 regulators, doctors and patients were
4 criminally misled into believing opioids
5 were safe and effective. In 2007, the
6 Department of Justice accused Purdue of
7 deceptively telling doctors that
8 OxyContin was safer and less addictive
9 than other drugs.

10 Did I read that correctly?

11 A. You did.

12 Q. When you forwarded this to
13 your colleague at Teva and your
14 third-party vendors, did you know about
15 the Department of Justice accusing Purdue
16 of deceptively marketing OxyContin?

17 A. I don't recall whether I
18 knew at that time or not, when I
19 forwarded the message. The message was
20 forwarded almost three years ago. So I
21 don't recall.

22 Q. Do you -- did you
23 subsequently do research into the
24 Department of Justice's accusations

1 against Purdue about its deceptive
2 marketing of OxyContin?
3 A. I don't recall doing any
4 research into the Department of Justice.
5 Q. Are you aware of whether or
6 not the Department of Justice brought
7 criminal charges against Purdue in
8 Virginia, near the Tennessee border?
9 A. I have -- no, I don't know.
10 MS. HILLYER: Objection.
11 Assumes facts not in evidence.
12 BY MR. GASTEL:
13 Q. That paragraph goes on to
14 say that, The company and several
15 executives pleaded guilty to misleading
16 doctors and were fined \$635 million.
17 Did I read that correctly?
18 A. You did.
19 Q. Did you know about Purdue's
20 guilty plea and their fine of \$635
21 million when you forwarded this e-mail?
22 A. I can't speak to what I knew
23 at the time I forwarded the e-mail.
24 Q. The paragraph goes on to

1 due to its marketing of Actiq opioids,
2 correct?
3 A. In part.
4 Q. Is that a yes?
5 A. Yes, in part.
6 I'm sorry.
7 Q. And in 2008, did you
8 personally have a role in marketing
9 Cephalon's Actiq product?
10 MS. HILLYER: Objection to
11 the form.
12 THE WITNESS: 2008?
13 BY MR. GASTEL:
14 Q. Yes.
15 A. Yes.
16 Q. I think I'm done with that
17 article.
18 - - -
19 (Whereupon, Teva-Bearer
20 Exhibit-23,
21 TEVA_MDL_A_03967973-979, was
22 marked for identification.)
23 - - -
24 MR. GASTEL: I'm going to

1 talk about something that you probably do
2 have knowledge on.
3 It says, In 2008, Cephalon
4 paid \$425 million in fines, partly for
5 marketing its Actiq opioid, which was
6 shaped like a lollipop, for use against
7 migraines and sickle-cell pain,
8 conditions for which the drug had not
9 been found safe and effective.
10 Did I read that correctly?
11 A. You did.
12 Q. And then the article goes on
13 to say, Actiq withdrew its lollipop but
14 by then there was no shortage of other
15 opioids available.
16 Did I read that correctly?
17 A. You did.
18 Q. When you forwarded this
19 article to your colleagues at Teva and
20 your third-party vendors, you were aware
21 that Cephalon had paid the \$425 million
22 fine, correct?
23 A. Correct.
24 Q. And that that was, in part,

1 hand you another document that
2 we'll mark as Exhibit-23.
3 BY MR. GASTEL:
4 Q. This is an e-mail from
5 Yousseff Kahn, sent to a variety of
6 people, including you, on August 24th,
7 2015.
8 Do you recall receiving this
9 e-mail?
10 A. I don't actually recall, but
11 I must have received it. I'm on the
12 e-mail chain.
13 Q. Sure.
14 And the subject is, CI news,
15 opioid use disorder, the continued rise
16 of opioid abuse and misuse.
17 Did I read that correctly?
18 A. You did.
19 Q. And it appears to be an
20 article written by Bill McCarberg.
21 A. Yes.
22 Q. Are you familiar with Dr.
23 McCarberg?
24 A. I know the name, but I don't

1 know specifically Dr. McCarberg.
 2 Q. And going down to the second
 3 full paragraph beginning, In 2013.
 4 Do you see that?
 5 A. Yes.
 6 Q. The article states, In 2013
 7 in the United States, 40,982 deaths by
 8 drug overdose occurred. Of these, 16,235
 9 were the result of opioid analgesics.
 10 Did I read that correctly?
 11 A. You did.
 12 Q. And the article states that
 13 that's equivalent to 46 deaths every day.
 14 Did you have any reason to
 15 dispute those statistics when you
 16 received this e-mail in August of 2015?
 17 A. I don't have the references.
 18 If it's referenced, then I would have no
 19 reason to dispute it, until I read the
 20 reference and determined whether it was
 21 appropriate or not.
 22 Q. And the article goes on to
 23 state that, While the age-adjusted rate
 24 for drug overdose deaths related to

1 opioids increased at a rate of 19 percent
 2 per year from 2000 to 2006, the rates
 3 slow down from 2 percent from 2006 to
 4 2013.
 5 Did I read that correctly?
 6 A. Yes.
 7 Q. It says, The age-adjusted
 8 rate for opioid overdose deaths declined
 9 from 5.4 to 5.1 per 100,000 from 2010 to
 10 2013.
 11 Did I read that correctly?
 12 A. Yes.
 13 Q. Do you have any reason to
 14 doubt that those statistics were accurate
 15 when you received this e-mail back in
 16 2015?
 17 A. Again, I don't recall
 18 receiving it. Therefore, I don't know
 19 what my impression was at the time.
 20 It appears -- I don't see a
 21 reference.
 22 Q. And then --
 23 A. Yes, it is referenced.
 24 Sorry.

1 Q. Assuming those statistics
 2 are true --
 3 A. Yes.
 4 Q. -- would you characterize
 5 that, personally, as an opioid crisis?
 6 MS. HILLYER: Objection to
 7 form. Lack of foundation. Calls
 8 for speculation.
 9 THE WITNESS: Opioid crisis?
 10 MS. HILLYER: And assumes
 11 facts not in evidence.
 12 THE WITNESS: Yeah, based on
 13 this article, I would not -- I
 14 would not -- I don't recall ever
 15 having a personal discussion or
 16 professional discussion around --
 17 based on this article. The
 18 crisis, I don't recall that.
 19 BY MR. GASTEL:
 20 Q. And so --
 21 A. The crisis.
 22 Q. -- we've looked now at a
 23 couple of articles that you received in
 24 2015 as it relates to what you described

1 as the public health crisis of abuse and
 2 addiction.
 3 And I think your testimony
 4 previously was that you started receiving
 5 these when you were putting together
 6 business plans and marketing promotional
 7 efforts for Vantrela; is that correct?
 8 MS. HILLYER: Objection.
 9 Mischaracterizes testimony on a
 10 couple of counts.
 11 But you can answer.
 12 THE WITNESS: The way I'm
 13 making that -- I'm giving that
 14 information is based on the date.
 15 BY MR. GASTEL:
 16 Q. Sure.
 17 A. In preparation -- if the
 18 date aligned with preparation for the
 19 strategy, et cetera, for Vantrela, then
 20 the answer would be yes.
 21 Q. And what do you mean by the
 22 strategy for Vantrela?
 23 A. The payer strategy, as was
 24 described previously for any product.

1 Q. And the payer strategy being
2 the way that you were going to promote in
3 marketing -- and market Vantrela to
4 third-party payers, right?

5 A. Correct.

6 Q. And a big part of that was
7 going to be promoting it as an abuse
8 deterrent, correct?

9 A. Correct.

10 Q. And you were going to do
11 that because the opioids on the market
12 were subject to abuse and misuse,
13 correct?

14 MS. HILLYER: Objection to
15 form.

16 THE WITNESS: There were
17 abuse-deterrent formulations
18 available, as well as
19 nonabuse-deterrent formulations
20 available.

21 BY MR. GASTEL:

22 Q. Well, we have just gone
23 through some articles going through --
24 that you forwarded and that you received

1 talking about opioid abuse, right?

2 A. Right.

3 Q. And so -- and you believe
4 that you received these articles as part
5 of developing the Vantrela payer
6 strategy, right?

7 A. Correct. Yes.

8 Q. And it would only make sense
9 to market Vantrela as an abuse deterrent
10 to these third-party payers if they were
11 on the market at that time, prescription
12 opioids, that were subject to abuse,
13 right?

14 MS. HILLYER: Objection to
15 form.

16 THE WITNESS: Once again,
17 it's a treatment option the
18 physicians would have, based on
19 identifying appropriate patients,
20 that they could then determine if
21 an abuse-deterrent formulation of
22 an opioid was appropriate.

23 BY MR. GASTEL:

24 Q. And so do you recall the

1 active opioid ingredient in Vantrela?

2 A. Hydrocodone.

3 Q. And was the purpose of
4 trying to sell Vantrela an attempt to
5 displace some of the current hydrocodone
6 market?

7 MS. HILLYER: Objection to
8 form.

9 THE WITNESS: It was, again,
10 another option for physicians,
11 when they determined it was
12 appropriate to prescribe for a
13 patient an abuse-deterrent
14 formulation, which is just another
15 treatment option.

16 - - -

17 (Whereupon, Teva-Bearer
18 Exhibit-24,
19 TEVA_MDL_A_03551263-266, with
20 attachment, was marked for
21 identification.)

22 - - -

23 BY MR. GASTEL:

24 Q. Let me show you a document

1 that we'll mark as Exhibit-24.

2 MR. GASTEL: This is
3 actually Exhibit-2.

4 MS. HILLYER: Do you have a
5 copy for me?

6 MR. GASTEL: Yes, I'm sorry.

7 MS. HILLYER: That's okay.
8 Thanks.

9 BY MR. GASTEL:

10 Q. So this is a long e-mail
11 string that begins on March 11, 2016.
12 And it looks like you are eventually
13 forwarded this string on Thursday, April
14 14th, 2016.

15 Do you see that?

16 A. Yes, I do.

17 Q. Do you recall receiving this
18 e-mail?

19 A. I don't recall.

20 Q. Let's flip through it a
21 little bit and set the stage, if you
22 will.

23 The e-mail chain begins with
24 an e-mail from Jeffrey Callahan --

1 A. Correct.
 2 Q. -- to Dana Kelly on March
 3 11, 2016.
 4 Do you see that?
 5 A. I do.
 6 Q. Who is Mr. Callahan?
 7 A. He was in forecasting.
 8 Q. And who is Ms. Kelly?
 9 A. Finance.
 10 Q. And it says, Good morning,
 11 Dana. Attached is the template that
 12 provides you with units for new IR hydro
 13 and oxy scenarios that we constructed
 14 yesterday.
 15 Did I read that correctly?
 16 A. You did.
 17 Q. And IR hydro and oxy is a
 18 reference to immediate-release
 19 hydrocodone and Oxycodone?
 20 A. Correct.
 21 Q. And those are prescription
 22 opioids, right?
 23 A. Yes.
 24 Q. And it looks like Mr.

1 Callahan forgot to attach the document.
 2 And so he sends another
 3 e-mail that says, It would help if I
 4 remembered to attach the file.
 5 Do you see that?
 6 A. Yes, I do.
 7 Q. And then on March 15th,
 8 2016, Ms. Kelly responds, Hello. Please
 9 find the LRP units for IR hydro and oxy
 10 attached.
 11 Did I read that correctly?
 12 A. Yes.
 13 Q. What does "LRP units" mean?
 14 MS. HILLYER: Objection to
 15 the extent it calls for
 16 speculation.
 17 THE WITNESS: I don't know.
 18 BY MR. GASTEL:
 19 Q. Well, I'm happy that I can
 20 also be confused on that term, then, too.
 21 Going back up, eventually
 22 when you joined the e-mail chain, I
 23 believe, on April 14th, 2016, at the top
 24 of the second page of this document, with

1 Bates stamp ending 264, Mr. Jeffrey
 2 Dierks forwards you this e-mail chain.
 3 Do you see that?
 4 A. I do.
 5 Q. I think you've previously
 6 testified.
 7 But just again for the
 8 record, who is Mr. Dierks?
 9 A. He was the brand director
 10 for Vantrela.
 11 Q. And in his role as brand
 12 director for Vantrela, he was the person
 13 who was principally involved in
 14 attempting to market and develop
 15 promotional material for Vantrela; is
 16 that fair?
 17 A. His team, yes.
 18 Q. And it says, Deb, welcome
 19 any of your thoughts on the below, as we
 20 need to finalize some of the assumptions
 21 for the development of the IR P&Ls.
 22 Did I read that correctly?
 23 A. Yes.
 24 Q. And is the term "IR P&Ls" a

1 reference to immediate-release profit and
 2 loss?
 3 A. Yes.
 4 Q. So is it fair to say that
 5 Mr. Dierks is at least partly trying to
 6 figure out with this analysis whether or
 7 not Teva could make money from marketing
 8 and selling Vantrela?
 9 MS. HILLYER: Objection.
 10 Calls for speculation.
 11 THE WITNESS: This, as I
 12 read it, is in reference to
 13 another product, Valzedo, which we
 14 were looking potentially -- and,
 15 again, I'm reading this, so I
 16 believe this is what it was
 17 referring to, not Vantrela --
 18 Valzedo, which was an
 19 immediate-release version of
 20 hydrocodone.
 21 BY MR. GASTEL:
 22 Q. And so eventually you,
 23 again, flipping over to the next page,
 24 you send an e-mail to Joseph Smith.

1 Do you see that?
2 A. Yes.
3 Q. And it says, What were the
4 assumptions by channel? I know we
5 typically assume 78 -- 70 to 80 percent
6 commercial. With the new forecast, did
7 anything change?
8 Did I read that correctly?
9 A. You did.
10 Q. What does that mean, that
11 "we typically assume 70 to 80 percent
12 commercial"?
13 A. Well, when we look at the
14 patient population for branded products,
15 we assume, based on data, that 70 to 80
16 percent of the patients will have
17 commercial insurance for which we are
18 promoting the product.
19 And I'm asking if that
20 changed, because Joe also is a
21 forecaster.
22 Q. Got it.
23 And then he responds back
24 with this breakdown, right, in the e-mail

1 "reimbursed"?
2 A. Your question, I believe,
3 was about patients. Patients pay cash.
4 Medicaid, commercial and Part D are
5 insurers. Therefore, the insurer
6 reimburses, for the patient, the cost of
7 the drug.
8 Q. And then the reference to
9 IMS data, that's IMS Health data, right?
10 A. Yes.
11 Q. For the record, will you
12 just explain what IMS data is?
13 MS. HILLYER: Objection to
14 the extent it calls for
15 speculation.
16 THE WITNESS: They have a
17 variety of data. And its claims
18 data, prescription -- typically,
19 claims data. And it's used for --
20 to assess utilization.
21 BY MR. GASTEL:
22 Q. Sure. And I want to take a
23 look at some of this IMS data that you
24 were forwarded in this e-mail from Mr.

1 dated April 18th, 2016 at 7:10 a.m.?
2 Do you see that?
3 A. Yes.
4 Q. And it says, Was looking for
5 you Friday and just connected with Jeff
6 and found out you were out until
7 Thursday. I'd assume the below splits
8 based off the IMS data, since they
9 probably won't change significantly.
10 Did I read that correctly?
11 A. Yes.
12 Q. And then he provides a
13 breakdown between Medicaid, cash,
14 commercial, and Part D --
15 A. Yes.
16 Q. -- correct?
17 A. Yes.
18 Q. And this is, essentially,
19 various ways that end users of
20 prescription opioids can pay for those
21 opioids, right?
22 A. That, you know, are
23 reimbursed.
24 Q. And what do you mean by

1 Joseph Smith on April 18th, 2016. And
2 it's attached to Exhibit-24.
3 A. Okay.
4 Q. And I believe it's the fifth
5 page of this exhibit.
6 And it says, across the
7 top -- it's an Excel spreadsheet --
8 MS. HILLYER: Sorry, again,
9 just for the record, these are not
10 consecutive Bates.
11 MR. GASTEL: Yeah, well,
12 it's the attachment to the April
13 18th, 2016 e-mail.
14 MS. HILLYER: Then it would
15 be consequent -- there's no
16 attachment. Which April 18th?
17 MR. GASTEL: From Joseph
18 Smith.
19 MS. HILLYER: So the middle,
20 the second e-mail chain, okay.
21 So do you have that -- it's
22 just not consecutive, so we don't
23 actually have, sitting here
24 today --

1 MR. GASTEL: I don't Bates
2 stamp them, you Bates stamp them.
3 MS. HILLYER: I do.
4 MR. GASTEL: If you want the
5 exhibits consecutive with the
6 e-mails they're attached to, Bates
7 stamp them that way.
8 MS. HILLYER: We do. This
9 is not a consecutive -- there's no
10 attachment to this top e-mail,
11 which has no attachment, so it is
12 consecutively Bates, if it was
13 attached to the second. You just
14 didn't print that out and bring it
15 as an exhibit. And that's not our
16 fault.
17 And I just want to make it
18 clear for the record that there's
19 two different Bates numbers and
20 you should probably put in the
21 record what those Bates numbers
22 are for future reference, so
23 nobody gets confused.
24 MR. GASTEL: Well,

1 I didn't run the report.
2 BY MR. GASTEL:
3 Q. But you received it, right?
4 A. Well, to the point you made
5 earlier, just because it says -- I don't
6 know -- this was a long trail of
7 forwarded. It doesn't necessarily mean
8 he forwarded me the attachment.
9 I don't recall receiving it,
10 is what I'm trying to say.
11 Q. Well, let's go back to the
12 e-mail chain there.
13 Because it finishes off with
14 an e-mail from you to Joseph Smith that
15 says, Sorry I missed you on Friday. As
16 of now, I would use these assumptions.
17 A. Yes.
18 Q. Right? That's what it says?
19 A. That has nothing to do with
20 the attachment. That's these assumptions
21 at the bottom here, the channel --
22 Q. So --
23 A. -- not at the bottom, the
24 Medicaid, cash --

1 regardless, the attachment is --
2 was produced natively to us as
3 Bates stamp document
4 TEVA_MDL_A_03550081.
5 BY MR. GASTEL:
6 Q. And across the top on this
7 document it says, Product.
8 Do you see that?
9 A. Yes.
10 Q. And that would indicate that
11 this is the product of IMS Health data
12 that's been collected, correct?
13 A. Yes. It would appear that,
14 yes.
15 Q. And the next column over, it
16 says, MAT, March 2014, Medicaid TRx.
17 Do you see that?
18 A. I do.
19 Q. Is that a -- is that a
20 reference to a monthly average total?
21 MS. HILLYER: Objection to
22 the extent it calls for
23 speculation.
24 THE WITNESS: I don't know.

1 MS. HILLYER: Wait. One at
2 a time.
3 THE WITNESS: Pardon me?
4 MS. HILLYER: One at a time.
5 BY MR. GASTEL:
6 Q. So that doesn't refresh your
7 recollection as to whether or not you
8 looked at the attachment?
9 MS. HILLYER: Objection to
10 form. Improper refreshing. And
11 mischaracterizes the document.
12 THE WITNESS: Typically,
13 this type of data is summarized by
14 either someone in forecasting, et
15 cetera. And this is the summary
16 that I would have looked at,
17 rather than scrutinizing the Excel
18 sheet.
19 BY MR. GASTEL:
20 Q. Sure. So you would have --
21 A. They are the experts on IMS
22 data.
23 Q. So you would have looked at
24 the analysis, is that what you're saying,

1 to determine whether or not the
 2 assumptions were correct?
 3 A. I don't recall ever
 4 receiving this document. These
 5 colleagues are the experts in our company
 6 that provide forecasting information. I
 7 would have no reason to challenge their
 8 summary, which, to me, is what I'm
 9 looking at here, which is Medicaid, cash,
 10 commercial, Part D.
 11 Q. Well, let's go to the last
 12 page, then.
 13 A. Okay.
 14 Q. Okay. And you see that the
 15 last page of this document has some
 16 numbers on it.
 17 Let's do the second-to-last
 18 page, okay? Do you see that it has --
 19 the very bottom page says, Medicaid,
 20 4,339,185, 4.62 percent.
 21 Do you see that?
 22 MS. HILLYER: No.
 23 BY MR. GASTEL:
 24 Q. Very last column.

1 Q. And I read that correctly?
 2 A. I believe you did.
 3 Q. And then it's the exact same
 4 number in the e-mail of April 18th, 2016,
 5 right?
 6 A. Right.
 7 Q. And then Part D, again, on
 8 the last page, 26,699,350.
 9 Did I read that correctly?
 10 A. You did.
 11 Q. 28.03 percent.
 12 Did I read that correctly?
 13 A. You did.
 14 Q. And then if you flip back to
 15 the e-mail on April 18th, 2016, it's the
 16 exact same numbers there in that e-mail,
 17 right?
 18 A. Yes.
 19 Q. To which you responded, You
 20 can use those assumptions, right?
 21 A. Yes.
 22 Q. And then if you take a look
 23 at what that document is summarizing,
 24 again, going back to the second-to-last

1 A. I see that, yes.
 2 Q. So go back to the e-mail
 3 that you received --
 4 A. Yes.
 5 Q. -- on April 18th, 2016.
 6 And it says, Medicaid, the
 7 exact same numbers and exact same
 8 percentage.
 9 Do you see that?
 10 A. I do.
 11 Q. Let's flip to the last page,
 12 the one labeled cash, 6,658,519, 6.99
 13 percent.
 14 Do you see that?
 15 A. I do.
 16 Q. Let's go back to your e-mail
 17 that you received on April 18th, 2016.
 18 Exact same numbers for cash,
 19 right?
 20 A. Yes.
 21 Q. Commercial, last page,
 22 57,485,347, 60.36 percent.
 23 Do you see that?
 24 A. I do.

1 page, you see, in what is essentially the
 2 product column, it's HYCD/APAP.
 3 All the way down.
 4 A. I see.
 5 MS. HILLYER: This is what
 6 he's looking at.
 7 THE WITNESS: No, I know
 8 what he's looking at. I'm looking
 9 at the previous to see -- yes.
 10 Okay.
 11 BY MR. GASTEL:
 12 Q. And is it your understanding
 13 that that's a reference to hydrocodone
 14 with acetaminophen?
 15 A. Yes.
 16 Q. And so according to this IMS
 17 Health database that you were forwarded
 18 on April 8th, 2016, there were
 19 approximately, if I'm doing my math
 20 right, 95 million prescriptions for these
 21 hydrocodone products?
 22 MS. HILLYER: Objection.
 23 Calls for speculation. Lack of
 24 foundation. She's testified she

1 doesn't recall ever receiving
 2 this, reviewing it, and had
 3 nothing to do with it.
 4 MR. GASTEL: She received
 5 the e-mail that has this data in
 6 it. And she told --
 7 MS. HILLYER: She doesn't
 8 recall that. And she said --
 9 MR. GASTEL: And she told
 10 her colleague --
 11 MS. HILLYER: Hold on. Let
 12 me state my objection.
 13 MR. GASTEL: -- that she --
 14 that he can go ahead and use the
 15 assumptions.
 16 MS. HILLYER: For the
 17 record, she testified that she
 18 doesn't recall receiving this.
 19 This document doesn't reflect that
 20 she received this. She testified
 21 that the assumptions were in
 22 reference to the substance of what
 23 he wrote in the underlying e-mail,
 24 not in this attachment.

1 me to do the math?
 2 MS. HILLYER: Give her a
 3 calculator. I mean, come on,
 4 she's here as a fact witness.
 5 This is -- I mean, at some
 6 point --
 7 MR. GASTEL: You're the one
 8 who is making this hard. Don't
 9 get mad at me.
 10 MS. HILLYER: If you want
 11 her to do the math, give her --
 12 MS. GASTEL: You're the one
 13 who's making this hard.
 14 MS. HILLYER: -- put the
 15 math up there.
 16 No, I'm not. She has
 17 nothing to do with this document.
 18 And somebody asked for a
 19 break. So after this answer,
 20 we'll take a break.
 21 And just for the record, Ms.
 22 Bearer, why don't you state what
 23 you're actually doing, the math.
 24 THE WITNESS: I'm taking the

1 You can ask your question
 2 and she can answer it. But my
 3 objections are on the record.
 4 THE WITNESS: Rephrase,
 5 sorry.
 6 BY MR. GASTEL:
 7 Q. So if I'm doing my math
 8 right, that's 95 million prescriptions,
 9 right?
 10 MS. HILLYER: Same
 11 objections.
 12 THE WITNESS: Well, I'm not
 13 adding it up, so I'll -- if you
 14 want to add all this together and
 15 it comes to that, I'll believe
 16 you.
 17 BY MR. GASTEL:
 18 Q. Well, let's just do simple
 19 math.
 20 What's 56 plus 26?
 21 A. Okay. I got you.
 22 MS. HILLYER: You're asking
 23 her to do the math?
 24 THE WITNESS: You're asking

1 totals that were provided on the
 2 e-mail for the channels of
 3 Medicaid, cash, commercial and
 4 Part D, and I'm adding them
 5 together.
 6 Unless I did it incorrectly,
 7 it comes to -- what I show, unless
 8 I made a mistake, it's 95,242,401.
 9 MS. HILLYER: Just leave it,
 10 in case there's more math.
 11 BY MR. GASTEL:
 12 Q. And that was derived,
 13 according to this e-mail, from the IMS
 14 data that Joe sent to you on April 18th,
 15 2016?
 16 MS. HILLYER: Objection to
 17 form. You're asking her whether
 18 the number she just put into the
 19 calculator was derived from the
 20 IMS data in this e-mail?
 21 MR. GASTEL: Yes.
 22 MS. HILLYER: Objection to
 23 form. Same objections. Lack of
 24 foundation. Calls for

<p style="text-align: right;">Page 365</p> <p>1 speculation. She testified that</p> <p>2 she doesn't know that she received</p> <p>3 the attachment.</p> <p>4 Go ahead.</p> <p>5 THE WITNESS: I don't --</p> <p>6 BY MR. GASTEL:</p> <p>7 Q. The e-mail itself references</p> <p>8 the IMS data, right?</p> <p>9 A. So --</p> <p>10 Q. And you have no reason to</p> <p>11 doubt that Joe is -- that Joe, when he</p> <p>12 forwarded this e-mail on April 18th,</p> <p>13 2016, was lying to you that the source of</p> <p>14 this material was IMS data, right?</p> <p>15 A. No.</p> <p>16 MS. HILLYER: Objection to</p> <p>17 form.</p> <p>18 THE WITNESS: I don't have</p> <p>19 any reason to suggest he lied.</p> <p>20 His role is very different than</p> <p>21 mine.</p> <p>22 BY MR. GASTEL:</p> <p>23 Q. Sure.</p> <p>24 A. So if he runs the data, then</p>	<p style="text-align: right;">Page 366</p> <p>1 I don't go back and do what you asked me</p> <p>2 to do, which is add it up.</p> <p>3 Q. Sure.</p> <p>4 A. I don't.</p> <p>5 Q. And then you respond that,</p> <p>6 As of now, I would use those assumptions,</p> <p>7 right?</p> <p>8 A. Yes.</p> <p>9 Let me be clear. For the --</p> <p>10 what were the assumptions by channel,</p> <p>11 we're talking percentages.</p> <p>12 Q. Sure. But the percentages</p> <p>13 are based on these prescription numbers,</p> <p>14 right?</p> <p>15 A. Yes.</p> <p>16 Q. And that's 95 million</p> <p>17 prescriptions, right?</p> <p>18 MS. HILLYER: Objection to</p> <p>19 form.</p> <p>20 THE WITNESS: Based on the</p> <p>21 calculator that you provided me</p> <p>22 and my adding it up, that's what</p> <p>23 the number came to.</p> <p>24 BY MR. GASTEL:</p>
<p style="text-align: right;">Page 367</p> <p>1 Q. Does that sound like a lot</p> <p>2 of prescriptions to you, 95 million?</p> <p>3 MS. HILLYER: Objection to</p> <p>4 form.</p> <p>5 THE WITNESS: Compared to</p> <p>6 what?</p> <p>7 BY MR. GASTEL:</p> <p>8 Q. Compared to anything.</p> <p>9 MS. HILLYER: Objection to</p> <p>10 form.</p> <p>11 THE WITNESS: I don't have</p> <p>12 a -- I mean, it's a large number,</p> <p>13 I'll agree to that. It's a large</p> <p>14 number.</p> <p>15 MS. HILLYER: Let's go off</p> <p>16 the record.</p> <p>17 VIDEO TECHNICIAN: Going off</p> <p>18 the record. 4:27 p.m.</p> <p>19 - - -</p> <p>20 (Whereupon, a brief recess</p> <p>21 was taken.)</p> <p>22 - - -</p> <p>23 VIDEO TECHNICIAN: Back on</p> <p>24 record. 4:35.</p>	<p style="text-align: right;">Page 368</p> <p>1 BY MR. GASTEL:</p> <p>2 Q. Going back to the Time</p> <p>3 Magazine article, flipping to the</p> <p>4 document Bates labeled 62, which I</p> <p>5 believe is the third --</p> <p>6 MS. HILLYER: Which exhibit</p> <p>7 number?</p> <p>8 BY MR. GASTEL:</p> <p>9 Q. -- the third page.</p> <p>10 MS. HILLYER: What exhibit?</p> <p>11 MR. GASTEL: 22. The Time</p> <p>12 Magazine article.</p> <p>13 THE WITNESS: What page? I</p> <p>14 didn't hear you. I'm sorry.</p> <p>15 BY MR. GASTEL:</p> <p>16 Q. 162.</p> <p>17 A. Okay.</p> <p>18 Q. About a little over halfway</p> <p>19 down the article, it says, By 2011 -- do</p> <p>20 you see that paragraph beginning?</p> <p>21 A. Yes.</p> <p>22 Q. By 2011, the number of</p> <p>23 opioid prescriptions written for pain</p> <p>24 treatment had tripled to 219 million.</p>

1 Did I read that correctly?
 2 A. Yes, you did.
 3 Q. And we just looked at some
 4 IMS Health data that suggested that there
 5 were 95 million prescriptions for
 6 hydrocodone.
 7 Does the number 219 million
 8 cause you any concern?
 9 MS. HILLYER: Objection to
 10 form.
 11 THE WITNESS: I mean, again,
 12 reading this out of context,
 13 there's no reference. Therefore,
 14 I don't have an opinion.
 15 BY MR. GASTEL:
 16 Q. Well, when you forwarded
 17 this article to your colleagues at Teva
 18 and your third-party vendors and you saw
 19 that Time Magazine was reporting
 20 prescription rates of 219 million, did
 21 that cause you concern at the time?
 22 MS. HILLYER: Objection to
 23 form.
 24 THE WITNESS: This is

1 form. And mischaracterizes the
 2 document and the testimony.
 3 You can answer.
 4 THE WITNESS: This was an
 5 article on the public health
 6 crisis, which we monitored
 7 everything that was -- you know,
 8 we tried to keep current with what
 9 was in the public domain.
 10 BY MR. GASTEL:
 11 Q. But the term "public health
 12 crisis of abuse and addiction" is your
 13 term; it's in your cover e-mail?
 14 A. That's correct.
 15 Q. That was the language that
 16 you chose to use, right?
 17 A. That's correct.
 18 MR. GASTEL: Subject to my
 19 previous objection -- oh, let me
 20 ask -- I'm sorry, let me ask one
 21 last question.
 22 BY MR. GASTEL:
 23 Q. Where do you live, Ms.
 24 Bearer?

1 information that was in the public
 2 domain that our customers would
 3 see. And, therefore, the purpose
 4 of forwarding it on was looking at
 5 the landscape, we're preparing to
 6 launch an abuse-deterrent
 7 formulation.
 8 BY MR. GASTEL:
 9 Q. And you're preparing to
 10 launch an abuse-deterrent formulation
 11 because there was widespread abuse and
 12 addiction of opioids, right?
 13 MS. HILLYER: Objection to
 14 form. And asked and answered.
 15 MR. GASTEL: Let me
 16 rephrase.
 17 THE WITNESS: Yeah, okay.
 18 BY MR. GASTEL:
 19 Q. You were planning on
 20 launching an abuse-deterrent formulation
 21 in order -- in response to what you
 22 described as the public health crisis of
 23 abuse and addiction, right?
 24 MS. HILLYER: Objection to

1 A. Pennsylvania.
 2 Q. What is your actual address?
 3 A. [REDACTED]
 4 [REDACTED]
 5 Q. And who lives there with
 6 you?
 7 A. No one.
 8 MS. HILLYER: Objection to
 9 form.
 10 BY MR. GASTEL:
 11 Q. Do you have any plans to
 12 move any time soon?
 13 A. I don't really have an
 14 opinion, at this point, of whether I'm
 15 going to move or not.
 16 Q. Do you own that residence?
 17 MS. HILLYER: Objection.
 18 THE WITNESS: Yes.
 19 MR. GASTEL: All right.
 20 Subject to my previous objection,
 21 Ms. Bearer, thank you for your
 22 time. I have no more questions
 23 today.
 24 THE WITNESS: Okay.

<p style="text-align: right;">Page 373</p> <p>1 MS. HILLYER: Just to</p> <p>2 respond to your previous</p> <p>3 objection, Teva is not in</p> <p>4 violation of any protocol or</p> <p>5 guidance concerning the state and</p> <p>6 federal protocol.</p> <p>7 We produced everything in a</p> <p>8 timely manner and answered all of</p> <p>9 the questions that you had.</p> <p>10 I do have a few brief</p> <p>11 redirect questions for Ms. Bearer.</p> <p>12 - - -</p> <p>13 EXAMINATION</p> <p>14 - - -</p> <p>15 BY MS. HILLYER:</p> <p>16 Q. Ms. Bearer, do you recall,</p> <p>17 when was the launch of Fentora?</p> <p>18 A. 2007.</p> <p>19 Q. Would you or anyone at Teva</p> <p>20 have -- or Cephalon, excuse me, have</p> <p>21 marketed Actiq after the launch of</p> <p>22 Fentora?</p> <p>23 A. No.</p> <p>24 Q. Did you ever market or</p>	<p style="text-align: right;">Page 374</p> <p>1 promote Actiq for off-label uses?</p> <p>2 A. No.</p> <p>3 Q. Did you ever market or</p> <p>4 promote Fentora for off-label uses?</p> <p>5 A. No.</p> <p>6 MS. HILLYER: I have no</p> <p>7 further questions.</p> <p>8 Off the record.</p> <p>9 VIDEO TECHNICIAN: This ends</p> <p>10 today's deposition. Going off the</p> <p>11 record at 4:40 p.m.</p> <p>12 - - -</p> <p>13 (Whereupon, the deposition</p> <p>14 concluded at 4:40 p.m.)</p> <p>15 - - -</p> <p>16</p> <p>17</p> <p>18</p> <p>19</p> <p>20</p> <p>21</p> <p>22</p> <p>23</p> <p>24</p>
<p style="text-align: right;">Page 375</p> <p>1 CERTIFICATE</p> <p>2</p> <p>3</p> <p>4 I HEREBY CERTIFY that the</p> <p>5 witness was duly sworn by me and that the</p> <p>6 deposition is a true record of the</p> <p>7 testimony given by the witness.</p> <p>8</p> <p>9</p> <p>10</p> <p>11 Amanda Maslynsky-Miller</p> <p>12 Certified Realtime Reporter</p> <p>13 Dated: January 9, 2019</p> <p>14</p> <p>15</p> <p>16</p> <p>17 (The foregoing certification</p> <p>18 of this transcript does not apply to any</p> <p>19 reproduction of the same by any means,</p> <p>20 unless under the direct control and/or</p> <p>21 supervision of the certifying reporter.)</p> <p>22</p> <p>23</p> <p>24</p>	<p style="text-align: right;">Page 376</p> <p>1 INSTRUCTIONS TO WITNESS</p> <p>2</p> <p>3 Please read your deposition</p> <p>4 over carefully and make any necessary</p> <p>5 corrections. You should state the reason</p> <p>6 in the appropriate space on the errata</p> <p>7 sheet for any corrections that are made.</p> <p>8 After doing so, please sign</p> <p>9 the errata sheet and date it.</p> <p>10 You are signing same subject</p> <p>11 to the changes you have noted on the</p> <p>12 errata sheet, which will be attached to</p> <p>13 your deposition.</p> <p>14 It is imperative that you</p> <p>15 return the original errata sheet to the</p> <p>16 deposing attorney within thirty (30) days</p> <p>17 of receipt of the deposition transcript</p> <p>18 by you. If you fail to do so, the</p> <p>19 deposition transcript may be deemed to be</p> <p>20 accurate and may be used in court.</p> <p>21</p> <p>22</p> <p>23</p> <p>24</p>

<p style="text-align: right;">Page 377</p> <p>1 -----</p> <p>2 E R R A T A</p> <p>3 -----</p> <p>4 PAGE LINE CHANGE/REASON</p> <p>5 _____</p> <p>6 _____</p> <p>7 _____</p> <p>8 _____</p> <p>9 _____</p> <p>10 _____</p> <p>11 _____</p> <p>12 _____</p> <p>13 _____</p> <p>14 _____</p> <p>15 _____</p> <p>16 _____</p> <p>17 _____</p> <p>18 _____</p> <p>19 _____</p> <p>20 _____</p> <p>21 _____</p> <p>22 _____</p> <p>23 _____</p> <p>24 _____</p>	<p style="text-align: right;">Page 378</p> <p>1 ACKNOWLEDGMENT OF DEPONENT</p> <p>2</p> <p>3 I, _____, do</p> <p>4 hereby certify that I have read the</p> <p>5 foregoing pages, 1 - 374, and that the</p> <p>6 same is a correct transcription of the</p> <p>7 answers given by me to the questions</p> <p>8 therein propounded, except for the</p> <p>9 corrections or changes in form or</p> <p>10 substance, if any, noted in the attached</p> <p>11 Errata Sheet.</p> <p>12</p> <p>13 _____</p> <p>14 DEBORAH BEARER DATE</p> <p>15</p> <p>16 Subscribed and sworn</p> <p>17 to before me this</p> <p>18 _____ day of _____, 20____.</p> <p>19</p> <p>20 My commission expires: _____</p> <p>21</p> <p>22 _____</p> <p>23 Notary Public</p> <p>24</p>
<p style="text-align: right;">Page 379</p> <p>1 LAWYER'S NOTES</p> <p>2 PAGE LINE</p> <p>3 _____</p> <p>4 _____</p> <p>5 _____</p> <p>6 _____</p> <p>7 _____</p> <p>8 _____</p> <p>9 _____</p> <p>10 _____</p> <p>11 _____</p> <p>12 _____</p> <p>13 _____</p> <p>14 _____</p> <p>15 _____</p> <p>16 _____</p> <p>17 _____</p> <p>18 _____</p> <p>19 _____</p> <p>20 _____</p> <p>21 _____</p> <p>22 _____</p> <p>23 _____</p> <p>24 _____</p>	